

**A Comparative Review of Community Health Representatives
Scope of Practice in International Indigenous Communities**



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Overview

Purpose and Background

In October 2003, the International Network in Indigenous Health Knowledge and Development (INIHKD) held an inaugural meeting in Townsville, Australia with participation from Australia, Canada, New Zealand and the United States of America. During that meeting, it was acknowledged that each of these four countries maintained community health representatives/workers (CHR/Ws) as an integral part of their indigenous health care system. As discussion ensued, it was discovered that the CHR/Ws in indigenous communities across all four countries seemed to be facing similar issues and challenges – particularly with respect to 'scope of practice'. Indeed, it became apparent that, if given the opportunity, each country could benefit greatly from the others by sharing more about the issues and challenges facing their respective CHR/Ws.

With funding and direction from Health Canada, the National Indian and Inuit Community Health Representatives Organization (NIICHO) of Canada has facilitated this international comparative study: *A Comparative Review of CHR/Ws' Scope of Practice in International Indigenous Communities*. Certainly both Health Canada and NIICHO have recognized the escalating needs regarding scope of practice issues facing CHR/Ws within Canada. In fact, in July of 2003, a round-table discussion on standards and accreditation for CHR/Ws was coordinated by NIICHO (and attended by Health Canada, among other stakeholders) as a first step in the initiative to develop and manage national occupational standards of practice and accreditation for CHR/Ws in Aboriginal communities across Canada. In acknowledgement of such issues within Canada, as well as in recognition of the issues internationally (in Australia, New Zealand and the United States), Health Canada and NIICHO have engaged their resources to complete this international comparative study. Participation from key stakeholders identified in Australia, Canada, New Zealand and the United States has proven to be essential to the successful completion of this study.

Within this study, the intention has been to explore issues and challenges for CHR/Ws in more detail by highlighting the following areas:

- historical overview of the indigenous peoples in each country
- review of the evolution of CHR/Ws and the developments regarding scope of practice for CHR/Ws in each country (including specific initiatives and projects)
- analysis of survey questionnaire data that addressed:
 - o job description/scope of practice
 - o organizational structure
 - o budgets and salaries
 - o standards and accreditation
 - o professional relationships
 - o challenges and best practices.

The data within this study should prove valuable to all involved with the structuring of policies and strategies and with the development, review and revision of standards of practice and systems of accreditation for CHR/Ws. As well, the information (including acknowledgement of key international CHR/W stakeholders) should prove valuable to the organizers of the next International Network in Indigenous Health Knowledge and

Development (INHKD) Forum, which is being planned for June 2005 in the host nation of Canada.

Terminology

For the purposes of this study, please consider the following terms and definitions:

Accreditation: the process of officially recognizing as meeting certain (designated) standards.

Certification: formal documents attesting a level of achievement and/or requirements (e.g.: achievement in coursework).

CHR/W: Community Health Representative/Worker

Credentialing: the process of assessing and conferring approval on a person's suitability to provide a defined type of service.

Indigenous Communities, Peoples and Nations: are those which, having a historical continuity with the pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing in those territories, or parts of them.¹

Prior Learning Assessment: similar to credentialing, the process of assessing and conferring approval on a person's suitability to provide a defined type of service based on a person's abilities/skills gathered from experience rather than from specific certifications.

Scope of Practice: the range of domains, the parameters and/or the framework that describe one's work.

Standards: agreed attributes and processes designed to ensure that a service or method will be performed consistently at a designated level.

Methodology and Study Participants

Through funding and direction from Health Canada, the National Indian and Inuit Community Health Representatives Organization (NIICHO) of Canada – with contributions from participant stakeholders – has facilitated this international comparative study. Research methods for this study have included literature reviews, a survey questionnaire and personal interviews.

Study participants/key stakeholders were selected from the four nations of Australia, Canada, New Zealand and the United States of America. Potential stakeholders representing various organizations (federal/state/provincial/territorial governments, community health organizations and CHR/W advocates/affiliates) were identified and invited to participate in the study. Stakeholder participation was described to involve periodic communication with the project coordinator/researcher, feedback on project deliverables (as requested), and the completion of a survey questionnaire. Upon confirmation of involvement, stakeholders were actively engaged in the research (referred to as 'participatory action research') such that participants/stakeholders provided:

- names/contact info of other potential stakeholders and/or resources
- feedback for the creation of the survey questionnaire
- feedback on part one of the project (historical overview)
- completion of the survey questionnaire, and
- feedback on the final project report.

A list of project participant stakeholders and their contact information can be found in Appendix A of this report.

The project proceeded according to the following work plan phases:

Phase 1:

- Identify major resources and key stakeholders.
- Contact key stakeholders to present project, request and secure involvement/interest, and invite suggestions and comments.

Phase 2:

- Develop brief historical literature review that details for each country: the history of indigenous people; the history of CHR/Ws; the history of the development of established CHR/W support organizations; and the history of developments with respect to scope of practice for CHR/Ws.
- Share the brief historical literature review with stakeholders as background information and invite feedback.

Phase 3:

- Develop survey questionnaire; obtain input on survey content from stakeholders.
- Distribute survey questionnaire to stakeholders; collect survey questionnaire and collate data.
- Develop extensive literature/research review to present state of affairs in each of the four countries regarding scope of practice and related human resource issues for CHR/Ws. This review includes response data from survey questionnaires.

Phase 4:

- Based on survey results, summarize and analyze the similarities and differences in each of the four countries; address the question "what valuable information can our four countries share and how can we learn from one another?"
- Combine extensive literature/research review and survey summary/analysis to create final project report.

Phase 5:

- Present draft of final project report to stakeholders for feedback.
- Complete any revisions to produce final project report.

While the project duration was longer than originally estimated (mostly because of the delay in the return of survey questionnaires from stakeholders), all phases of the project as outlined were completed successfully. It should be noted for future projects of similar intent that the international context of the study will require a flexible work plan timeline in that it can be challenging to secure information/participation from several stakeholders in different nations with different time zones and with different personal and professional demands. For example, while ideally a focus group of all stakeholders might be organized to share/secure feedback, this is not possible with an international study operating under particular parameters (e.g.: limited budget).

Historical Overview

While a detailed summary of the history of indigenous people is beyond the scope of this paper, it is valuable to those concerned about indigenous health to begin with some sense of such history for several reasons:

- history has had a major impact on the physical, mental, emotional, and spiritual health and well-being of indigenous people;
- history impacts the current relationships of indigenous people with their health care providers and with the mainstream health care system; and
- historical policies and attitudes often still exist today.

Despite the diversity of indigenous peoples world-wide, it is suggested that they share common problems and issues that have arisen from the prevailing, or invading, society. As has been evidenced throughout history, the lands and cultures of nearly all indigenous peoples have come under threat at some point in time. Certainly in Australia, Canada, New Zealand and the United States of America, indigenous people have had to face the potential loss of their distinct cultures as they have confronted discrimination and pressure to assimilate into prevailing societies.

Indeed, historical pressures have created issues that persist in indigenous societies today and affect, among many things, the health of indigenous people. CHR/Ws have evolved to support the health needs specific to their indigenous communities. Following is a historical analysis of four nations (Canada, Australia, New Zealand and the United States of America) that illustrates a striking similarity regarding historical issues and the evolution of CHR/Ws.

Canada

Indigenous People

Indigenous people in Canada are collectively referred to as "Aboriginal" – an inclusive term that refers to three distinct and unique groups: First Nations, Inuit and Métis.² Aboriginal people represent 50 culturally distinct language groups in Canada and may refer to themselves by their specific tribal affiliation (such as Mi'kmaq, Cree, Mohawk, Ojibwa) or First Nations, Inuit or Métis. It has recently been estimated that 1.3 million (3.8 per cent) of Canadians have Aboriginal ancestry.³

First Nations people are considered to be the 'first people' of Canada. First Nations people have been referred to as "Indian" in certain literature (e.g.: Indian Act), although the term is a misnomer based on an assumption by early European explorers, and can be offensive to some First Nations people.⁴ First Nations people are further classified by the Canadian government according to whether they are registered as "status" or "non-status" and "treaty" or "non-treaty," entitling them to certain rights and benefits at the federal and community levels respectively.

The Métis are a group of Aboriginal people whose ancestry can be traced to the intermarriage of European men and First Nations women in the western provinces during the 17th century.⁵ The Métis have historically been excluded from treaty negotiations, the Indian Act and associated rights and benefits.

Inuit is a general term for a group of culturally similar indigenous people of the Arctic. The Canadian Inuit traditionally lived above the tree line of what is now Canada, and are part of a larger circumpolar Inuit population that includes Greenland, Alaska and Russia. The previous term "Eskimo" is now generally considered a misnomer. Historically, the Canadian Inuit have registered with the federal and territorial governmental organizations in order to obtain certain rights and benefits, including health benefits.⁶

Colonization and its Effects

Colonization has had a disruptive impact on the health and well-being of Aboriginal people in Canada. Early European colonization of the Americas, and Canada specifically, brought epidemics of disease, massacres, war and slavery, suppression of language, ceremonies, culture and "spiritual way of life," residential schools, destruction of native family systems, domination by other races and societies, imposition of "unnatural" social order, and pollution of "mother earth." An historical outline of colonization in Canada might include:⁷

- 15th century: European explorers charted the waters and lands of the Americas and encountered indigenous people; gradually European colonists established themselves in the new lands (including the lands of Canada) and claimed power in governance.
- The Royal Proclamation of 1763 (a proclamation that ensured Aboriginal title recognition) called for negotiated settlement of land transactions through treaty or purchase; unfortunately the governmental approach shifted from negotiations to assimilation and resulted in the removal of Aboriginal people from their homelands.
- The Indian Acts of 1876, 1880 and 1884 outlawed Aboriginal ceremonies such as the sun dance and the potlatch.

- By 1871, the population of Aboriginal people, estimated at 500,000 prior to European contact, had dropped to 102,000.
- From 1849 to 1983, 100 residential schools came into operation in Canada; Indian Act legislation in 1920 made school attendance compulsory for all First Nations children between the ages of 7 and 15; the 'scoop' of Aboriginal children to residential schools where language and culture were actively suppressed was prevalent.
- Since the 1970s, claims processes have assisted treaty groups seeking fulfillment of treaty obligations which dated back to the Royal Proclamation of 1763; claims processes were also pursued in parts of the country where native title had not previously been established with treaty agreements.
- Since the 1970s, indigenous people have been afforded rights with respect to hunting, fishing and minerals.

In more recent history (1998 statistics), estimates suggest that:⁸

- the gap in life expectancy between Aboriginal Canadians and other Canadians is seven years;
- infant mortality rates have dropped between 1981 and 1998 (in half), but are still higher than those of other Canadians;
- the unemployment rate of 'Registered Indians' on reserve is three times the Canadian average; and
- between 1984 and 1994, the number of children remaining in school until high school graduation has doubled to 75 per cent and post-secondary enrolments tripled.

The following statistics indicate that the overall health of Aboriginal people in Canada has progressed in recent years, but there is still much need of improvement as indicated by comparisons to the national population:⁹

- Life expectancy at birth has improved among the First Nations population. In 2000, it rose to 68.9 years for males and 76.6 years for females, an increase from 1980 of 13.1 per cent and 12.6 per cent respectively. Life expectancy for Inuit in Nunavut for 1999 has been estimated at 67.7 years for males and 70.2 years for females.
- In 1999, the First Nations birth rate was 23 births per 1,000 population, two times the comparable rate for Canada. Over half (58 per cent) of First Nations women who gave birth in 1999 were under 25 years of age. First Nations females aged 10 to 14 had an age-specific birth rate nine times that of the average rate for Canada for the same age group.
- The 1999 First Nations infant mortality rate was 8 deaths per 1,000 live births, or 1.5 times higher than the Canadian infant mortality rate of 5.5. By contrast, the 1979 First Nations infant mortality rate was 27.6 deaths per 1,000 live births, a rate that has been steadily declining.
- The First Nations and the Canadian populations had similar proportions of births with low birth weight in 1999; however, almost twice as many First Nations births were classified as high birth weight in the same year.
- The crude mortality rate for First Nations in 1999 was 354.2 deaths per 100,000 population. The four leading causes of death were injury and poisoning, circulatory diseases, cancer and respiratory diseases. For each of the causes of death, the rate has decreased when compared with the 1991 to 1993 period, from 22.4 per cent for cancer to 40.9 per cent for respiratory diseases, such as pneumonia and bronchitis.
- The most common cause of death for First Nations people aged 1 to 44 was injury and poisoning. Among children under 10, deaths were primarily unintentional

(accidental). Suicide and self-injury were the leading causes of death for youth and adults up to age 44. For First Nations people aged 45 and older, circulatory diseases were the most common causes of death. These trends parallel the Canadian population as a whole. Motor vehicle collisions were a leading cause of death in all age groups.

- With respect to suicide, all First Nations age groups up to age 65 are at increased risk, compared with the Canadian population. First Nations males are at higher risk than females.
- In 1999, First Nations people experienced a disproportionate burden of many infectious diseases. These include pertussis (3 times higher), chlamydia (7 times higher), hepatitis A (5.3 times higher) and shigellosis (almost 20 times higher).
- The proportion of Canada's total AIDS cases contracted by Aboriginal people climbed from 1.0 per cent in 1990 to 7.2 per cent in 2001. Over that same period, the tuberculosis rate among First Nations people remained eight to ten times that seen in the Canadian population as a whole.
- Dental decay rates for Aboriginal children in Ontario are two to five times higher than rates among non-Aboriginal children. They are far less likely to be decay-free.
- Shelter is a significant issue among First Nations communities, as only 56.9 per cent of homes were considered adequate in 1999. Adequate shelter is defined as not needing minor or major repairs or replacement.

Australia

Indigenous People

It is suggested that the ancestors to the indigenous Australians arrived from Southeast Asia to Australia between 50,000 to 100,000 years ago, indicating more than 1,250 generations. The word *aboriginal*, in use in English since the 17th century to mean "first or earliest known; indigenous," was used in Australia as early as 1789. The word *aboriginal* was soon capitalized and became the standard name for indigenous Australians. Strictly speaking, *Aboriginal* is an adjective and *Aborigine* is a noun. It is therefore correct to refer to the indigenous people of mainland Australia as *Aboriginal Australians/people* or *Australian Aborigines*, although today, indigenous people of Australia increasingly dislike being called *Aborigines*.¹⁰

In addition to the Aboriginal Australians, the indigenous people of Australia include the distinct group of *Torres Strait Islanders*. The Torres Strait is the body of water, approximately 150 km wide, which lies between Australia and Papua New Guinea. In the strait lie the Torres Strait Islands, inhabited by Torres Strait Islanders. While in 1975 the Islanders were established to be citizens of Australia (as opposed to citizens of Papua New Guinea), in 1982 legal proceedings were set forth by Torres Strait Islanders to establish traditional land ownership of the islands. In 1992, after ten years of hearings before the Queensland Supreme Court and the High Court of Australia, it was found that the indigenous people were the rightful owners of the land. Since this ruling, both Aboriginal Australians and Torres Strait Islanders are referenced when speaking of the indigenous people of Australia.¹¹ According to census statistics from 1998, approximately two per cent (353,000 individuals) of the population of Australia were defined as Aboriginal and Torres Strait Islander.¹²

Aboriginal Australians may be further distinguished according to their tribal affiliation or their language groupings. For example, there are several Aboriginal tribes, including the Airiman, Barara, and Worimi, to name just a few. Likewise, groupings of spoken language over large areas suggest that the *Koori* live in New South Wales and Victoria, the *Murri* in southern Queensland, the *Palawa* in Tasmania, etc.¹³ The Australian Bureau of Statistics (ABS) estimates that there are between 418,800 and 476,900 indigenous people in Australia.

Colonization and its Effects

Prior to contact with the European colonists in the late 18th century, most Aboriginal Australians were hunter-gatherers with complex oral, cultural and spiritual values based on reverence for the land and a belief in the 'Dreamtime'. Dreamtime refers to the ancient time of creation and the present-day reality of dreaming. There were several different Aboriginal groups, each with their own individual culture, belief structure and language (approximately 200 different languages at the time of European contact).¹⁴

The impact of colonization, including the implementation of policies such as 'protectionism', 'segregation' and 'assimilation', contributed to the fragmentation of Aboriginal and Torres Strait Islander societies as well as to the physical and psycho-social problems that are endemic today. A historical outline upon colonization of Australia might include:^{15 16 17}

- 1788 marks the beginning of British colonization of Australia.
- Disease, loss of land (and thus food resources) and violence/massacres reduced the Aboriginal population by an estimated 90 per cent during the 19th century and early 20th century; despite the prominence of violence and the effects of loss of land, it is estimated that 90 per cent of the Aboriginal population decline was the result of disease that spread with the advance of the European colonists (e.g.: chickenpox, smallpox, influenza... which the Aboriginal people had no understanding of or resistance to).
- The appropriation of prime land and the spread of livestock over vast areas made traditional Aboriginal lifestyles less viable.
- Aboriginal men, women and children became a significant source of labour for many of the large sheep/cattle stations that began to dominate the outback Australia; typically, the work of the Aboriginal worker was voluntary or virtual slavery and in 1965 equal pay legislation was introduced as a supportive measure, but it unfortunately brought about widespread unemployment and more hardship.
- Since 1975 and to date, the Australian government has attempted to address issues arising from Aboriginal land and resource dispossession, including land rights legislation in respective states, Aboriginal heritage legislation, native title legislation and joint management legislation.
- Despite efforts, Australian indigenous people do not enjoy any constitutional or treaty recognition, unlike in Canada, New Zealand and the United States where treaties have been signed.
- In Australian government, there are no dedicated seats in parliament or any special measures to promote the election of Aboriginal and Torres Strait Islander candidates to Commonwealth, State or Territory Parliaments; instead, representatives are elected to the Aboriginal and Torres Strait Islander Commission (ATSIC), a body with both administrative and advisory functions.
- During the first half of the 20th century, native welfare boards were established in various states. These instituted a policy of separating indigenous children from their

parents based upon racial stereotyping. In 1997, there was a national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. The federal government accepted some of the recommendations from the inquiry and allocated \$63 million for remedial action, however did not apologize. Most state, territorial and local governments did issue apologies.

According to the Australian parliamentary report, a more recent historical account states that in 1998 Aboriginal and Torres Strait Islanders:¹⁸

- had a lower life expectancy than any other first world country indigenous population (60 years for males and 61 years for females; 15 to 20 years less than that of other Australians);
- had an infant mortality rate three times that of the total Australian population and an adult mortality rate six to eight times that of the total population;
- showed school participation rates to be significantly lower than for all Australians
- had an unemployment rate of 38 per cent compared to 9 per cent for the general population of the nation; and
- had family incomes that were on average \$10,000 per year below the rest of the population's.

Today, many Aboriginal Australians live in towns and cities around the nation, but a substantial number live in settlements in remote areas of rural Australia.

New Zealand

Indigenous People

The Māori are the indigenous people of New Zealand. The word Māori means 'normal' or 'ordinary person' in the Māori language. Māori is also the name of the language spoken by the indigenous people of New Zealand. It is believed that the Māori arrived in New Zealand sometime in the latter part of the first millennium AD, having come from Tahiti or some other part of eastern Polynesia. Māori myth and legend describe the arrival via large ocean-going canoes or 'waka'.¹⁹ In the 1996 census, 16 per cent of the population (approximately 580,000 individuals) indicated that they were of Māori descent.²⁰

Colonization and its Effects

The early European explorers of New Zealand, including Abel Tasman and James Cook, reported encounters with the Māori. These early reports described the Māori as a fierce and proud warrior race; intertribal warfare was a way of life.²¹

A historical account of the colonization of New Zealand might include:^{22 23}

- As early as the 1780s Māori had encounters with European sealers and whalers as well as ex-convicts or deserters from visiting ships.
- Upon the introduction of muskets by those tribes in close contact with the Europeans, there was a period of bloody intertribal warfare known as the Musket wars, during which several tribes were effectively exterminated and others driven from their traditional territory.
- European diseases also devastated a large number of Māori during this period.

- As European missionary activity and settlement increased in the 1830s, various Māori chiefs signed treaties with the British Crown. The most significant was the Treaty of Waitangi, which gave the Māori British citizenship in return for a guarantee of property rights and tribal autonomy.
- In the 1860s, disputes over questionable land purchases led to the Māori wars, which resulted in significant tribal lands being confiscated by the colonial government.
- At the same time, the government offered state village schools to Māori communities who so wished; however, the use of the Māori language in schools was actively discouraged in order to encourage assimilation.
- With the loss of their land and the threat to their language and culture in the 19th century, the Māori population went into decline and by 1896 the Māori population had declined to approximately 42,000. It was believed that the Māori population might be entirely assimilated into the European population and cease to exist as a distinct race. Fortunately, this did not occur and the Māori population recovered and underwent a cultural revival of sorts in the 1960s and 1970s.

More recent historical accounts of New Zealand state:^{24 25}

- Since the 1970s, governments have attempted to compensate for the unjust confiscation of land and the violation of other property rights. A special court, the Waitangi Tribunal, was established to make recommendations on such issues.
- Today, the Māori have significant interests in the fishing and forestry industries.
- Today, the Māori language's status is equivalent to English in government and law.
- Today, Māori politicians have seven designated seats in the New Zealand parliament and consideration and consultation with the Māori are routine requirements for many New Zealand councils and government organizations.
- Between 1970 and 1988, mortality rates for Māori males and females declined by 42 per cent and 49 per cent respectively, whereas the comparable rates for non-Māoris in New Zealand declined by 21 per cent and 22 per cent respectively.
- The gap in life expectancy between Māori and non-Māori has dropped to five or six years.
- Secondary school retention rates have increased from 4 per cent in 1985 to 25 per cent in 1995.
- In 1998, the Māori unemployment rate was reported to be three times that of the non-Māori population.

United States

Indigenous People

In the United States, indigenous or Aboriginal people are commonly referred to as "Native Americans" or "American Indian" (living in the mainland United States) and "Alaska Native" (living in the state of Alaska). Several American organizations, both Aboriginal and non-Aboriginal, continue to use the term "Indian."²⁶ The name "Indian" is less desirable as it represents domination of European colonialists since it was bestowed by the explorer Christopher Columbus, who mistakenly believed that the places he found (America) were among the islands of the Indies.²⁷ In Alaska, because of legal use in the Alaska Native Claims Settlement Act (ANCSA) and because of the

presence of the Inuit, Yupik and Aleut peoples, the term "Alaskan Native" predominates.²⁸

Of the 2.6 million Native Americans and Alaska Natives (approximately 1 per cent of the total population), there are more than 560 federally recognized tribes in the United States, whose members live mainly on reservations and in rural communities in 35 states, mostly in the western U.S. and Alaska.²⁹

Colonization and its Effects

The European colonization of the Americas forever changed the lives and the cultures of the Native Americans. In the 15th to 19th centuries, Native American populations were decimated by the hardships of displacement, disease, and in many cases warfare and enslavement with Europeans. Historians argue that due to diseases brought by Europeans, and to which the Native Americans had no immunity, 80 per cent of some Indian populations may have died.^{30 31}

- In the early period, colonial governments and later the federal government of the United States treated the indigenous nations as they did foreign nations and allowed them to regulate their own affairs.
- 1816-1846: as time progressed, Europeans claimed dominion over all the territories of the future United States, limiting the sovereignty of indigenous nations living there.
- 1865-1890: the rapidly growing United States in the east gradually forced large numbers of Native Americans into marginal lands in areas farther and farther west. Authorities entered into numerous treaties at that time, but later nullified many for various reasons. On January 31, 1876, the United States government ordered all Native Americans to move into reservations or reserves, which drastically affected the Prairie culture that developed around the concepts of hunting, travel and trading.
- 1871: at the end of the treaty-making period, the United States Congress began a policy of narrowing tribal and individual indigenous rights and encouraging indigenous Americans to move from reservations. Assimilation, allotment and U.S. citizenship for the indigenous Americans became official policy goals and continued until late in the 1920s.
- In the late 19th century, in efforts to civilize 'Indians', reformers adopted the practice of educating native children in boarding schools. The boarding school experience existed from 1875-1928 and forbade 'Indian' children to speak their native languages and forced adoption of European-American cultural practices.
- Military defeat, cultural pressure, confinement on reservations, forced cultural assimilation, the outlawing of native languages and cultures, forced sterilizations, termination policies of the 50s and 60s, and slavery have had deleterious effects on Native Americans' mental and ultimately physical health.

Today in the indigenous communities of the United States of America:^{32 33}

- From 1961 to the present, political and legislative policies toward indigenous Americans have turned toward the general principle of self-determination.
- Contemporary problems include poverty, alcoholism, heart disease, diabetes and New World Syndrome.
- Native American communities endure and have consistently formed governments that administer Native American services (e.g.: firefighting, resource management, court systems for local ordinances, etc.).

- Gaming has become a leading industry with casinos operated by many Native American governments.
- Native American communities have also pursued and prevailed in various legal battles to secure rights to self-determination and use of various natural resources.

According to a statistical report of 1998:³⁴

- the gap in life expectancy between Native Americans and the general population of America narrowed from 11 years for men in 1940 and 15 years for women to four years and three years respectively in 1980; and
- the Indian labour force participation rates were lower and median family incomes were on average \$14,000 per year below other American families.

CHR/Ws and Developments in Scope of Practice

As has been evidenced in the historical analysis, there is a similarity in the four nations (Canada, Australia, New Zealand and the United States of America) such that the historical pressures placed upon indigenous people have created issues that persist in societies today and affect – among other things – the health of indigenous populations. As a response to such issues, CHR/Ws have evolved to support the health needs specific to their indigenous communities. Since their inception, however, the scenario for CHR/Ws has changed and the topics regarding scope of practice (e.g. standards and accreditation) have become paramount. Following is a description of the evolution of CHR/Ws and the developments to date regarding scope of practice in Canada, Australia, New Zealand and the United States.

Canada

Evolution of CHR/Ws in Indigenous Communities

By the 1900s, First Nations and Inuit communities were decimated by many factors including smallpox, tuberculosis, and other communicable diseases, but the health crisis was not being addressed on a national level. In 1904, the Department of Indian Affairs appointed a general medical superintendent to start medical programs and develop health facilities. In 1930, the first on-reserve nursing station was opened and was followed by the building of 17 regional 'Indian' hospitals. In 1945, the Department of National Health and Welfare was created and by 1950 there were 33 nursing stations, 65 health centers and 18 small hospitals dedicated to providing health care for Aboriginal people.³⁵

In 1962, the Medical Services Branch (MSB) of Health and Welfare Canada was created with the mandate to provide services to treaty Indians and Inuit people. It was the MSB that instituted the Community Health Representatives program in 1962, primarily for First Nations and Inuit communities that had restricted or no access to medical treatment or public health services. Over time, the number of CHRs in Canada has increased from 11 in 1962, to 400 in 1980, to over 1,000 today.³⁶

Since the inception of the CHR program, CHR/Ws' work in Canada has changed with an evolving society and health care system. In 1974, the Minister of National Health and Welfare tabled the *Policy of the Federal Government concerning Indian Health Services*. The policy reiterated that no statutory or treaty obligations existed to provide health

services to 'Indians'. However, the federal government wanted to ensure the availability of services by providing it directly where normal provincial services (were) not available, and giving financial assistance to indigent 'Indians' to pay for necessary services when the assistance (was) not otherwise provided. In 1979, a new Indian Health Policy was announced. The policy recognized the circumstances under which many 'Indian' communities were existing, which placed 'Indian' people at a grave disadvantage compared to most other Canadians in terms of health and sought a framework in which 'Indian' communities could remedy these conditions. The federal government recognized its legal and traditional responsibilities to 'Indians', and realized that only 'Indian' communities themselves could change these root causes and that to do so would require the wholehearted support of the larger Canadian community. The policy also flowed from the commitment of 'Indian' people to preserve and enhance their culture and traditions. The goal of federal Indian Health Policy was to achieve an increasing level of health in 'Indian' communities, generated and maintained by the 'Indian' communities themselves.³⁷

In the mid-1980s, the Medical Services Branch started to work towards transferring control of health services to First Nations and Inuit communities and organizations through the government's Strategic Policy, Planning and Analysis Directorate.³⁸ The objective of the directorate was to provide strategic policy and planning advice to senior management and regional offices of the First Nations and Inuit Health Branch (previously an arm of the Medical Services Branch) on key health-related issues and initiatives.³⁹ Further to this goal, in 1988 the Health Transfer Program was offered as a means to help improve the health status of Aboriginal people by increasing Aboriginal control over health care and has been viewed as a step towards self-determination. The Health Transfer Agreements that were adopted by many communities included transfer of the several programs including the CHR program. Unfortunately, studies have shown that one result of the Health Transfer Agreements has been the high turnover rate of staff (particularly nursing staff) as communities have found it difficult to retain such staff because they could not offer them attractive salaries and benefits. With the turnover of many members of the health staff, CHRs have tended to provide the only continuity and stability in health care in Aboriginal communities.⁴⁰

Indeed, as the health system has evolved and recognized issues in the Aboriginal community, so has the role of the CHR. At its inception, the principal role of the CHR was to focus on health education and promotion and further responsibilities included assisting health professionals by translating medical instructions to clients, dispensing medication, midwifery, home visitations and some treatment.⁴¹ Since then, the role of the CHR has changed considerably and has been found to vary from community to community and region to region. Likewise, working conditions, salaries, benefits and other details regarding 'scope of practice' have been found to vary widely. At the same time, other roles, similar to the CHR but different in terms of client base and range of responsibilities, have emerged in various jurisdictions. For example, in some areas, there might be Aboriginal Health Workers, Wellness Facilitators, Community Health Workers and other unregulated health workers. Some programs may focus specifically on one area such as prenatal and infant nutrition outreach program or HIV/AIDS and may provide these in off-reserve areas.

According to Health Canada today, Canada's national health care system is based on five fundamental principles: universality, portability, accessibility, comprehensiveness and public administration. Health care in Canada exists as a shared responsibility

between the federal, provincial and territorial governments. With the adoption of Health Transfer, it also exists as a shared responsibility with specific Aboriginal communities.

Developments in Scope of Practice

While the role of the CHR has changed considerably, there has been widespread recognition (among CHRs, the FNIHB, provincial CHR/W associations, regional Aboriginal health boards, regional Aboriginal councils, Aboriginal associations, the Assembly of First Nations, and the Royal Commission on Aboriginal Peoples) that CHR/Ws play an important role in health care, health education, and health promotion in First Nations and Inuit communities. The CHR is frequently the essential provider of health services, particularly in northern, remote, and/or isolated communities where there are no other health professionals or where retaining nurses has proven difficult. The Royal Commission on Aboriginal Peoples reaffirms, "One of the most successful programs involving Aboriginal people in promoting health of Aboriginal people is the Community Health Representative program."⁴² Both national and regional Aboriginal associations have supported the expansion and enrichment of the CHR program over the years, including supporting the concept of developing national occupational standards and accredited training for CHRs.⁴³

The changing role of CHRs might be attributed to:⁴⁴

- demographic changes and the increased incidence of chronic diseases
- the expanded role of bands, health boards and tribal councils in health and social services under Health Transfer Agreements
- the growth in the number of new health programs
- the demand for quality care on par with that enjoyed by other Canadians
- increasing mobility of CHRs who initially tended to be based in their home communities.

As the health status of First Nations and Inuit people remains disadvantaged in comparison to that of most other Canadians, there continues to be a critical need for improved access and delivery of a wide range of health care. Because CHRs play a central role in health promotion, education, and prevention, they must have the knowledge and skills to effectively and competently carry out their duties. Although CHR training needs have evolved, there continues to be regional disparities in expectations of scope of practice and opportunities for basic and advanced training. The lack of available, accessible, affordable, relevant, standardized, and accredited training continues to be a major impediment to skill upgrading and career mobility and advancement.

Regional and provincial working groups of CHR/Ws have been discussing national and regional scopes of duties for CHR/Ws, with the intent that this standardized training will help CHR/Ws achieve their full potential as health professionals. Regional programs that provide standardized training for CHR/Ws have already been implemented in some parts of the country, although there is no national standardization. For example, various educational/certification programs have been initiated in some of the provinces:

- Portage College offers a one-year CHR certificate program that may be taken at the Lac La Biche campus in Alberta and will soon be available by distance education. Credits are also transferrable as the first year of the Athabasca University's Bachelor of Human Services Professional Administration degree.

- Mohawk College offers a two-year Native Community Care – Counselling & Development diploma program. The program is offered from Brantford Campus and by distance education. The credits are transferable to a four-year degree program from Wilfred Laurier University.
- Yellowquill College (Manitoba) offers a 24-week First Nations Community Management diploma program that can be taken on a full-time or part-time basis. Additionally a 12-week module offers a First Nations Diabetes Training Program.
- Okanagan University College (British Columbia) offers a 36-week Aboriginal Health Worker certificate program. The certificate is offered in collaboration with Community Health Associates of British Columbia.
- Additional programs include:
 - College of North Atlantic (Labrador): certificate or diploma
 - Concordia University and Université du Québec à Chicoutimi (Quebec)
 - Cambrian and Confederation Colleges (Ontario)
 - Assiniboine College (Manitoba)
 - Saskatchewan Indian Institute of Technology (Saskatchewan)
 - Alberta Vocational College (Alberta)
 - Sal'i'shan Institute and Malaspina College (British Columbia)
 - Yukon College (Yukon)
 - Aurora College and Nunavut College (Northwest Territories)

From a nationwide perspective, NIICHO, as a national organization representing Aboriginal Community Health Representatives, has come forward to lead the initiative of developing and managing national occupational standards of practice and accreditation for Aboriginal CHRs. Health Canada has been most supportive in this venture.

It would seem appropriate for NIICHO to lead such an initiative of developing and managing national standards and accreditation since it serves as a non-governmental national organization incorporated to:

- upgrade the quality of health care of Indian and Inuit people to the standard enjoyed by the rest of the population of Canada;
- provide a forum for CHRs to communicate and exchange information with each other on various community health initiatives and on the improvement of the CHR program at the national level;
- create/promote awareness and understanding of the CHR program in Canada; and
- provide a mechanism and a means for advising First Nations and Inuit communities, Medical Services Branch and others on all matters pertaining to CHRs.⁴⁵

(Note: NIICHO was established in 1986 and incorporated in 1992 and is accountable to the political leaders of First Nations and Inuit communities through their CHRs.)

Specific Initiatives and Projects

In addition to the efforts of various colleges/universities in establishing educational programs, a number of other specific initiatives/projects have evolved with respect to the topic of 'Scope of Practice' for CHR/Ws in Canada, including:⁴⁶

- a 1997 study by the Canadian Public Health Association on the desirability/feasibility of developing occupational standards for Aboriginal health workers, including CHRs.
- a 1998 survey by the National Indian and Inuit Community Health Representatives Organization (NIICHO) on the development of occupational standards for CHRs.
- the development of a CHR code of ethics and national/regional scopes of duties by regional working groups of CHRs in efforts to provide national standards (NIICHO).

- various initiatives to enhance the training, working conditions, and professional status of CHRs by the National Indian and Inuit Community Health Representatives Organization (NIICHRO). They include comprehensive training packages on current health issues (HIV/AIDS, diabetes, reduction of the non-traditional use of tobacco, etc.), annual national training sessions for CHRs, a magazine circulated to all CHRs with up-to-date research and resources on a variety of health issues, a website, and a resource documentation centre.
- The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper (Ship, 1998; revised by Butler, 2003).
- Community Health Worker Job Classification Model (CHABC, June 1999).
- Legal Issues and the Role of the CHR – Alberta (Half & Ransom, 2003).
- Scope of Practice for CHRs - Alberta (FNIHB & Portage College, 2003).
- Standards and Accreditation for Community Health Representatives: Summary Report of Round-table Discussion Meeting (McCulla, July 2003).

Details regarding many of these valuable resources are listed in Appendix B. Two of these studies are described here in more detail.

1998 (2003) Study:⁴⁷

In 1998, Judith Ship produced a research paper entitled *The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper* (revised, 2003 – Butler). The paper provided substantial background on the need and support for occupational standards, and the benefits to all stakeholders should such occupational standards be implemented. The paper went on to list several valuable recommendations for further action. Recommendations included the following stages, given that a national organization like NIICHRO might be charged with overseeing the process:

- Planning the process
- Accommodating regional, local, and community differences
- Building support for and compliance with standards
- Determining the content of occupational standards
- Ensuring liability coverage
- Developing training curricula
- Developing content of curricula
- Providing training for current CHRs
- Setting entrance requirements for new CHRs
- Delivery of training
- Developing accreditation and certification practices.

It was proposed that the project be divided into five phases, the first two involving the development of occupational standards and the last three involving the implementation of standards through the development of an approved training program and an accreditation and certification process.

Phase 1 (Planning the Process) would entail setting up a standards development committee made up of stakeholders such as CHRs, Aboriginal health professionals, representatives of NIICHRO, band councils, health boards, educational institutions and the MSB. This committee would be empowered to make all the major decisions on standards development. This phase would also involve the collection of data to assist the committee in developing standards, the development of a communications strategy, and consultations with other organizations.

In Phase 2 (Producing National Occupational Standards), an occupational analysis workshop made up of health practitioners would develop a profile of the basic skills required by each CHR. The results of the workshop would then be collated in the first draft of an occupational standard and validated by workshop participants, the standards development committee, and, eventually, all stakeholders.

Phase 3 (Establishing an Approved Training Program) would involve developing competency requirements for CHRs (basic, advanced and specialized training), curricula for training programs, training delivery methods, and other pedagogical aspects.

In Phase 4 (Certification and Accreditation), links would be developed with educational institutions in each province and territory to ensure accreditation. The certification process and composition of certification boards would be determined.

Lastly, Phase 5 (Maintenance, Monitoring and Renewal) would involve setting up a management structure for implementation and compliance and the renewal of standards.

2003 Round-table Discussion:⁴⁸

Ship's study (1998) identified that there is broad-based support for the development of national occupational standards and accreditation for CHR/Ws. Further evidence of support has been the ***Round-table Discussion on Standards and Accreditation for Community Health Representatives*** which was held in July 2003 in Kahnawake, Quebec. NIICHO coordinated the round-table discussion as a first step in the initiative to develop and manage national occupational standards of practice and accreditation for CHRs in Aboriginal communities across Canada. The round-table discussion included involvement from a number of key stakeholders who participated in sharing perspectives and defining recommendations for future strategic directions and actions.

After having shared professional perspectives with regards to various issues surrounding the development and management of national occupational standards of practice and accreditation for CHRs, the round-table discussion turned to establishing solid recommendations for future strategic directions and actions. In efforts to establish a clear plan of action, the overall project was considered in terms of five phases – similar to and complimenting Ship's (1998) five phases. Recommendations were put forth addressing aspects of each of these phases.

Phase 1: round-table discussion meeting; adoption of an outcome statement; identification of key stakeholders and a steering committee; development of a communication strategy; development and completion of a concept proposal application; and development of a sector study.

Phase 2: research and produce national occupational standards; conduct an occupational analysis workshop; and develop a draft of national occupational standards and standards of practice.

Phase 3: establish approved training program.

Phase 4: develop processes for accreditation and certification.

Phase 5: develop systems for maintenance, monitoring and renewal.

Round-table Recommendations	Responsibility
1. Define and adopt an outcome statement.	Phase 1: draft completed at round table; process ongoing
2. Identify potential stakeholders and steering committee.	Phase 1: draft completed at round table
3. Coordinate stakeholders and steering committee; develop communication strategy.	Phase 1: to be completed by NIICHRO
4. Complete concept proposal application.	Phase 1: to be completed by NIICHRO
5. With support of key stakeholders, plan, research and develop sector study.	Phase 1: to be directed by Steering Committee and completed by Consultant
6. Conduct further research.	Phase 1: to be directed by Steering Committee and completed by Consultant
7. Extend sector study and research for other unregulated workers.	Phase 1: guidance by Steering Committee
8. Research, prepare and produce national occupational standards.	Phase 2: guidance by Steering Committee
9. Conduct occupational analysis workshop.	Phase 2: guidance by Steering Committee
10. Validate, finalize and distribute the occupational analysis; draft national occupational standards and standards of practice.	Phase 2: guidance by Steering Committee
11. Establish approved training program.	Phase 3: guidance by Steering Committee
12. Develop processes for accreditation and certification.	Phase 4: guidance by Steering Committee
13. Develop systems for maintenance, monitoring and renewal.	Phase 5: guidance by Steering Committee

2004 Project:

This project, ***A Comparative Review of Community Health Representatives' Scope of Practice in International Indigenous Communities***, is a further initiative intended to provide information and support to the process of developing standards and accreditation for CHRs in Canada.

Australia

Evolution of CHR/Ws in Indigenous Communities

As early as the 1930s and 40s, there were few, if any, health services available to Aboriginal and Torres Strait Islander people living in areas that were isolated from the non-Aboriginal population. During these times, various religious missions provided some of the necessary health care. Only during the last 30 to 40 years have government health departments assumed responsibility for the health care of all Aboriginal and Torres Strait Islander people. In 1967, the Council for Aboriginal Affairs was established and in 1972, the Labour government introduced the principle of self-determination wherein indigenous people sought control and management of their own culturally appropriate health service delivery. In 1971, the first Aboriginal Health Service was established. The following 30 years saw the formation of other community-controlled health services in rural, urban and remote areas of Australia and the

establishment of the role of the Aboriginal Health Worker (Australia's equivalent to the CHR/W).⁴⁹

The Aboriginal Health Worker profession originally evolved due to a lack of doctors, nurses and services available, mainly in the rural areas, and the means to pay for these services. The Aboriginal Health Worker professional group in Australia is said to have initially developed from the employment of Aboriginal people, mainly women, as leprosarium workers in the 1950s, and later as medical assistants in the Northern Territory in the 1960s. The role of the Aboriginal Health Worker was further developed in line with a Primary Health Care model for improving the health status of Indigenous communities; this model was formalized and promoted by the World Health Organization in 1978. This Aboriginal Health Worker role became extended to include skills in health promotion and community development.⁵⁰

Developments in Scope of Practice

The role of the Aboriginal Health Worker has undergone many changes since its inception and has expanded to include clinical, managerial and educational functions. Similar to indigenous health workers in fellow nations, there has been a historical lack of clarity of role definition. In the early 1990s, various initiatives sought to establish a clearer definition of the role of the Aboriginal Health Worker and associated competency standards.

In 1994, the federal government created the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the then Department of Human Services and Health to focus on the needs of indigenous Australians. In 1995, a government decision was made to transfer the responsibility for Aboriginal and Torres Strait Islander health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to OATSIH, which then assumed responsibility for providing funding to Aboriginal community-controlled health and substance misuse services previously administered by ATSIC. The strategy of OATSIH was – and is – to improve access to primary health care services for Aboriginal and Torres Strait Islander people. The aim is to provide coordinated clinical care, population health and health promotion activities towards illness prevention, early intervention and effective disease management. The strategy of OATSIH is based on the principle of a working relationship with the Aboriginal community-controlled health sector, ATSIC and state/territory governments. Today, the Australian government's Department of Health and Ageing oversees the Office for Aboriginal and Torres Strait Islander Health.⁵¹

In 1995, the Australian Health Ministers Advisory Council (AHMAC), supported by the National Health and Medical Research Council (NHMRC), identified the need to develop national competency standards for Health Workers. In 1996, National Competency Standards were developed for Aboriginal Health Workers throughout Australia by the National Community Services and Health Industry Advisory Board (HIAB), now Community Services and Health Industry Skills Council. The competencies were instituted to provide greater clarification of the knowledge and skills required of the Aboriginal Health Workers and to enable the comparability and transferability of the skills across Australia.⁵²

Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards, developed in 1996 and endorsed in 1998, were a milestone in national

recognition for the role of the Health Worker. However, these standards have been due for review for some time. The Community Services and Health Industry Skills Council (CS&H Industry Skills Council) – formerly Community Services and Health Training Australia (CSHTA) – as the peak body for the health and community services industries, has been contracted by the Australian National Training Authority (ANTA) to develop new national qualifications for Aboriginal Health Workers and Torres Strait Islander Health Workers. This project is presently underway and it is anticipated that new national Health Worker qualifications will be available in 2005.⁵³

The outcomes of the project are to be consistent with Strategy 11 of AHMAC's Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework. Strategy 11 states: "AHMAC endorses the development of an Aboriginal Health Worker vocational system which recognizes the need to support comprehensive primary health care practice roles at various levels and distinguish these from other vocational streams currently encompassed by the term Aboriginal Health Worker. The objective is to ensure that Aboriginal Health Workers are equipped with the skills necessary to deliver effective quality services to Aboriginal and Torres Strait Islander peoples. This should be achieved by development of a national competency-based training framework for Aboriginal Health Workers which would enable greater clarity of the scope of practice of Aboriginal Health Workers, and greater clarity of the terms and conditions of employment of Aboriginal Health Workers."⁵⁴

The competency standards are to "particularly ensure a consistent competency framework between State and Territory and community sectors, portability and 'safety to practice' in Aboriginal and Torres Strait Islander primary health care across a number of levels of qualification within the Australian Quality Training Framework(AQTF)." The Australian Quality Training Framework (AQTF) is a set of nationally agreed standards to ensure the quality of vocational education and training services throughout Australia. The AQTF ensures that all Registered Training Organizations (RTOs) and the qualifications they issue are recognized throughout Australia.⁵⁵

Specific Initiatives and Projects

1996 Project⁵⁶

The competency standards for Aboriginal Health Workers and Torres Strait Islander Health Workers of 1996 were developed by Community Services and Health Training Australia Ltd. and funded by the Commonwealth Department of Health and Family Services. They were endorsed by the Board of Community Services and Health Training Australia Ltd. and the National Training Framework Committee of the Australian National Training Authority. The packaging outlined in the standards was aligned with the Australian Qualification Framework (AQF) as follows:

Level in Competency Standards Document	AQF Level
Level A	Certificate III
Level B	Certificate IV
Level C	Diploma
Level D	Advanced Diploma

The standards were developed by talking with health workers and health service providers throughout Australia. An Aboriginal and Torres Strait Islander-controlled Project Management Committee (PMC) managed the processes of developing the standards, and project officers undertook consultations throughout Australia.

A number of drafts of the standards were prepared, consulted upon, and modified progressively. The first draft was developed from statements made by health workers in research projects which had previously been undertaken in Aboriginal health work and Torres Strait Islander health work. The various drafts of the standards were discussed with health workers throughout Australia, detailed feedback was received, and many changes were made.

This final draft of the competency standards was prepared in response to all the feedback that has been received on the various drafts. Upon being endorsed as "National Competency Standards for Aboriginal Health Workers and Torres Strait Islander Health Workers," these standards were then to be used to develop training, to assess staff and to promote quality service delivery. The plan was for the endorsed standards to be reviewed nationally within three years.

The process of developing the competency standards has been detailed and is certainly worth reviewing for nations/organizations wishing to initiate such a development. The outline of the development of these standards can be viewed in full at the following internet link: http://www.cshta.com.au/docs/upload/A&TSI_intro.doc. Further information may also be available from:

Community Services and Health Industry Skills Council
GPO Box 9848, Sydney NSW, 2001
Phone: 02 9263 3589
Fax: 02 9263 3599
Email: admin@cshisc.com.au
<http://www.cshisc.com.au>

2005 Project⁵⁷

The Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project, intended to finish in 2005 and presently in progress, was designed with the purpose of developing new national qualifications for Aboriginal and Torres Strait Islander Health Workers. The project will include a review of the National Competency Standards for Aboriginal Health Workers and Torres Strait Islander Health Workers developed in the late 1996.

Purpose:

One of the principal aims of this project is to ensure that national qualifications continue to accurately reflect the work roles of indigenous Health Workers. Additional purposes of the project, as detailed in the project overview, are to:⁵⁸

1. renew the competency standards (of 1996) so they are current
2. bring the standards in line with current technical requirements of the National Training Quality Council (NTQC). [Note: The NTQC endorses training packages and advises the ANTA Board on policies to ensure quality and national consistency of training outcomes and the relevance of training to industry and regional needs.]
3. identify and address problems which make the existing standards difficult to work with
4. identify gaps in current standards

5. meet some gaps with new units
6. flag for future development other gap areas
7. ensure a national framework for recognized training
8. ensure flexibility in packaging to accommodate local needs
9. ensure Health Worker training is part of the Vocational and Education Training (VET) system and can access benefits associated with this system including access to training dollars and articulation into other qualifications in the VET and tertiary sectors.

Role of Industry Skills Council

The Community Services and Health Industry Skills Council is the recognised peak national body providing advice on industry training needs to government.

The overall strategic direction for the Council is captured in its simple yet powerful vision as follows: *Australia will have a community services and health workforce with sufficient competence such that, if deployed and managed well, it will always respond appropriately to the needs of the Australian population so that their health and wellbeing is promoted, maintained, and where necessary restored.*

The Industry Skills Council's goals flow naturally from the vision. They are:

- Maximize benefits of the VET services and products for the community services and health industry.
- Ensure that the VET services and products are appropriate, current and flexible to meet the myriad of skill/knowledge needs of the community services and health workforce.
- Enhance mutual learning with a view to appropriately skilling the workforce to meet service needs.
- Increase attractiveness of the VET products and services to non-mainstream learners.
- Build research-based industry knowledge that is of high value to both the Skills Council and its industry partners in meeting current and future service demands.
- Ensure that the quality of VET services and products is maintained at the implementation level.
- Ensure that the workforce is capable of adequately meeting service needs.

In attempting to realize this vision, the Council intends to embark on a journey that makes it:

- *The front of mind source of information within the two industries in the area of skills and knowledge formation and assessment, especially for the VET sector, but possibly too for all areas of learning/training.*
- *A genuine and acknowledged leader in the industries, championing appropriate competency development to enable workers to perform their jobs well.*
- *A strong supporter of all in the two industries who would and can enhance workers' skills and knowledge, thus increasing their capacity to contribute and their utilisation by employers and workers.*

There are two roles for the Skills Councils mandated by ANTA but which are entirely consistent with the proposed vision and mission statements on the one hand, and the goals and activities on the other. The two mandated roles are:

Role 1: Assist industries, enterprises and their workforce to integrate skill development with business goals and support accurate industry intelligence on future directions -

including provision of strategic advice on industry skills needs to the *National Industry Skills Forum*.

Role 2: Actively support the development, implementation and continuous improvement of high quality, nationally recognised training products and services, including enhancing innovation, rationalising materials where there are cross industry synergies, and improving efficiency.

In keeping with the vision of the CS&H Industry Skills Council, the initial focus of the role will be putting in place Training Packages and associated support materials (especially for assessment) for each industry that better reflect industry requirements. But this will only be a start. There is a significant need to actively promote the appropriate utilisation of the Training Packages and other resources, and the Skills Council believes it will approach this role in a very active, hands-on manner in conjunction often with individual employers.

The CS&H Industry Skills Council works in partnership with industry bodies in all States and Territories to promote and foster a learning culture in the workplace and increase participation in training and aims to ensure that all people in the industry have access to nationally recognized skills development. The Industry Skills Council has developed a national training framework for the industry to ensure the delivery of high quality, relevant and flexible training. The framework is based on identifying workplace competencies and assessing on-the-job performance.

Role of State and Territory Working Groups:

Part of the communication strategy is the establishment of a Working Group in each state and territory to:

- be representative of all key stakeholder groups (e.g. Community-Controlled sector, Government sector, OATSIH and relevant RTOs and other organizations); and
- to cover the range of working environments in which Health Workers operate.

It is intended that the Working Groups will play a key role in ensuring that the outcomes of the project meet local requirements, and that all key stakeholders have been given an opportunity to participate.

Competency Standards:

The competency standards project must meet the Australian National Training Authority's (ANTA) requirements for the development, implementation and review of training packages.

Competency standards are industry-determined specifications of performance which set out the skills, knowledge and attitudes required to operate effectively in employment. Competency standards are made up of units of competency, which are themselves made up of elements of competency, together with performance criteria, a range of variables, and an evidence guide. Competency standards are an endorsed component of a 'Training Package' where a 'Training Package' is an integrated set of nationally endorsed standards, guidelines and qualifications for training, assessing and recognizing people's skills, developed by industry to meet the training needs of an industry or group of industries. Competency standards are also sometimes referred to as "units of competency", "units" or "competencies."

Qualifications:

Qualifications are created by packaging units of competency into meaningful groups. Qualifications are defined in accordance with the Australian Qualifications Framework (AQF). The level of qualification is determined by considering the autonomy, responsibility and accountability, complexity of skill and knowledge, contexts of application, choice and range of contingencies, and discretion and judgement of the related job roles.

The packaging of the units must be flexible and meaningful to the relevant industry. The structure of a qualification can include:

- **common core** units which must be attained to achieve a qualification
- **specialist** units associated with particular industry specialization
- **prerequisite** units which must be attained before attaining other specified units
- **elective** units which are optional.

Methodology:

The methodology for the project must reflect sound research practice and be able to demonstrate that all key stakeholder groups were given reasonable opportunity to actively participate and that the full range of work environments has been considered. Information from states and territories should be specific to units of competency and qualifications. This will include such things as:

- suggested changes to existing units
- identification of overlaps
- suggested use of units from other training packages or development of equivalence with these
- suggested new units to meet current gaps
- suggested packaging for qualifications.

Sources of information available to State and Territory Working Parties may include the following:

- literature reviews
- current relevant reports and projects
- courses currently delivered (both recognized / accredited and other)
- job descriptions / profiles
- actual job roles
- skills gap analysis
- anecdotal evidence.

Evidence gathering **processes** may include:

- forums
- workshops
- trial sites
- surveys (mailed out, downloaded from the project website(s), completed by individuals or organizations, completed in interviews or completed as part of other activities).

Evidence gathering **activities** may include:

- review of relevant state- and territory-based reports and projects
- collection and analysis of current job descriptions
- analysis of actual job roles to identify relevant units and useful combinations of these for packaging of qualifications

- analysis of existing courses to identify:
 - matches with current competency units
 - gaps in current competency units
- workforce skills gap analysis to identify skill development priority areas and gaps in existing standards against these
- review of existing standards to:
 - collect data on problematic units
 - identify overlaps, co-assessment and prerequisite issues.

Research Tools:

Research tools available as part of this Support Pack for State and Territory Working Parties include:

- survey for employers, survey for Health Workers and survey for training providers
- form for stakeholder to make suggestions about units of competency
- form for Trial Sites to provide validation information
- tool to map jobs to competencies (to be developed)

Project Stages:⁵⁹



- analysis of existing courses to identify:
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 - gaps in current competency units
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- tool to map jobs to competencies (to be developed)

Project Stages:⁵⁹



Similar to the 1996 project, the process of developing the competency standards and qualifications for this project has been detailed and is certainly worth reviewing for nations/organizations wishing to pursue such an initiative. The outline of the development of these standards can be viewed in full at the following internet link: http://www.cshisc.com.au/view_page.asp?ID=15. For further information on the Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards and Qualifications Project, contact Community Services and Health Industry Skills Council:

Project Manager: Natalie Collison
Address: GPO Box 9848, SYDNEY NSW 2001
Email: admin@cshisc.com.au
www.cshisc.com.au
Tel: 02 9263 3589
Fax: 02 9263 3599
Di Lawson is the Executive Officer of CS&H Industry Skills Council.

New Zealand

Evolution of CHR/Ws in Indigenous Communities

New Zealand became the first country in the world to regulate nurses nationally; in 1901 the Nurses Registration Act was passed and provided for the registration of trained nurses across the nation. At the same time, the Māori Councils Act was established to create public health programs and bring about improvements in the area of Māori health.⁶⁰ Today, the Māori philosophy towards health is based on a wellness or holistic health model. Māori health models include whare tapa whā, where the four cornerstones (or sides) of Māori health are whānau (family health), tinana (physical health), hinengaro (mental health), and wairua (spiritual health). For many Māori the major deficiency in modern health services is taha wairua (spiritual dimension).⁶¹

The Treaty of Waitangi is New Zealand's founding document and the Government acknowledges its obligations as a Treaty partner. Acknowledgement of the Treaty principles and the special relationship established under the Treaty between Māori and the Crown is a guiding principle in the New Zealand Health Strategy, the New Zealand Disability Strategy and He Korowai Oranga (the Māori Health Strategy), which collectively set out the Government's action on health. Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori, and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.⁶²

As a population group, Māori have, on average, the poorest health status of any group in New Zealand. As a response to the poor health status of Māori people that has evolved over time, the government of New Zealand funded small pilot projects with Māori Health Providers to attempt to address the issues. As a result, Māori Health Providers became established, and their contracts with the government reflected and enabled Māori to offer services that Māori clients could access.

The Māori Community Health Worker (MCHW) program has been funded as a part of the Māori Health Provider program for the last two decades. With regards to the

success of the Māori Community Health Worker, there is anecdotal evidence that links the role of the MCHW with the rise in life expectancy rates of Māori.

Developments in Scope of Practice

As a population group, Māori have, on average, the poorest health status of any group in New Zealand. The government and the Ministry of Health have made it a key priority to reduce health inequalities that affect Māori. He Korowai Oranga sets a direction for Māori health development in the health and disability sector for the next five to ten years. Whakatātaka - the Māori Health Action Plan 2002 - 2005 - sets out what the government will do to progress the aims of He Korowai Oranga over the next two three years. It links to other Māori health strategies and plans and ensures there is consistency as we work toward the common aim: *whānau ora*. A key objective of Whakatātaka is to maintain links with other strategic and action plans.⁶³

To date, the relationship between Māori and decision making and the implementation of health and disability services has been based on three key principles (derived from the Royal Commission on Social Policy) – Partnership, Participation and Protection. In He Korowai Oranga (the Māori Health Strategy) these three principles are clearly articulated in line with Māori expectations of their relationship with the Crown in the health and disability sector.

- Partnership: Working together with iwi, hapu, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- Participation: Involving Māori at all levels of the sector, in decision making, planning, development and delivery of health and disability services.
- Protection: Working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

The position of Māori Community Health Worker (MCHW) has yet to be formally defined and described. Likewise, the extra workloads and demands on the MCHW have largely gone unchecked and the role of the MCHW has become confusing.

Specific Initiatives and Projects

Support and Advocacy Organizations

hauora.com has grown out of the need for Māori health professionals, workers, and managers to take a coordinated, managed, and active approach to their own development. It is a national initiative involving a number of Māori-led health professional organizations and networks. The Māori health workforce is small in comparison to the Māori population and is significantly underrepresented in nearly all health occupational groups. At the same time, the demand for Māori health professionals and workers continues to increase. In response, hauora.com sees itself as a capacity building organization focusing on strategic funding, community development, managing workforce development programs, building a knowledge base and expertise to assist planning, working intersectorially to coordinate resources, and removing barriers to training opportunities.⁶⁴ hauora.com has initiated the printing of a newsletter to keep those advocates of Māori health informed and advised. For example, future meetings relevant to Māori Community Health Workers are advertised in this newsletter.

More recent initiatives have seen the evolution of the organization *Te Whiringa*, which has been established as a charitable trust in September 2003 for the purpose of receiving funding from the Ministry of Health to achieve the following outcomes:

1. establish a national association for MCHWs
2. define the role of the MCHW
3. develop competencies for the MCHW.

With little having been done in past in terms of such an initiative, the work of *Te Whiringa* will be all that much more important to the Māori Community Health Worker.

United States of America

Evolution of CHR/Ws in Indigenous Communities

The principal legislation authorizing federal funds for health services to recognized Indian tribes is the Snyder Act of 1921. It authorized funds "for the relief of distress and conservation of health . . . [and] . . . for the employment of . . . physicians . . . for Indian tribes throughout the United States." Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide tribes the option of either assuming from the IHS the administration and operation of health services and programs in their communities, or to remain within the IHS-administered direct health system. Congress subsequently passed the Indian Health Care Improvement Act (P.L. 94-437), which is a health-specific law that supports the options of P.L. 93-638. The goal of P.L. 94-437 is to provide the quantity and quality of health services necessary to elevate the health status of American Indians and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of those services. Through P.L. 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 13 hospitals, 158 health centers, 28 residential treatment centers, 76 health stations, and 170 Alaska village clinics.

Congress initiated the American CHR Program in 1968 in order to provide a health care program with an outreach component that met the specific tribal health care needs of Native American and Alaskan Native governments and organizations as supported by the Indian Health Service (IHS). The CHR program became governed by the Indian Health Care Improvement Act of 1988 and has been overseen by the Indian Health Services (IHS).

The Indian Health Service is the principal federal health care provider and health advocate for Indian people. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states. According to the IHS (1991), the Community Health Representative Program in the United States "provides curative, preventative and rehabilitative services in those areas in which services would not otherwise be available to American Indian and Alaska Native people."⁶⁵ The CHR program is based on the concept that indigenous community members, trained in the basic skills of health care provision, disease control, and prevention, can successfully effect change in community acceptance and utilization of health care resources.

In fiscal year 1992, the Indian Health Service (IHS) spent \$39 million for 1,500 CHR's in 260 programs and in fiscal year 2004, \$51 million was spent for approximately 1,500 CHR's in 284 programs. The program is funded through contracts, grants, or cooperative agreements based on the Indian Self-Determination and Education Assistance Act (P.L. 93-638).⁶⁶

The IHS acknowledges that needs vary tremendously among tribes, and no single job description of a CHR can account for the multiplicity of duties and responsibilities that these important paraprofessionals shoulder. According to legislation, however, there is an ideal of what services the CHR program should provide. Title 25 (Chapter 18, General Provisions, Section 1616), of the U.S. legislative code indicates that the 'Secretary' should maintain a CHR program under which the service provides for the training of Indians as health paraprofessionals and uses such paraprofessionals in the provision of health care, health promotion and disease prevention services to Indian communities. The Secretary, acting through the Community Health Representative Program of the Service, shall:

- provide a high standard of training for paraprofessionals to Community Health Representatives to ensure that the Community Health Representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program;
- in order to provide such training, develop and maintain a curriculum that:
 - combines education in the theory of health care with supervised practical experience in the provision of health care, and
 - provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;
- maintain a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and maintain programs that meet the needs for such continuing education;
- maintain a system that provides close supervision of Community Health Representatives;
- maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and
- promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.⁶⁷

The IHS Headquarters is located in Rockville, Maryland. The IHS strives for maximum tribal involvement in meeting the needs of its service population. There are more than 560 federally recognized tribes in the United States. Their members live mainly on reservations and in rural communities in 35 states, mostly in the western U.S. and Alaska. Structurally, there are 12 IHS administrative units, called Area Offices, which are located in:

Aberdeen Area: Serves North Dakota, South Dakota, Iowa, and Nebraska

Alaska Area: Serves the State of Alaska

Albuquerque Area: Serves New Mexico, Colorado, and Texas

Bemidji Area: Serves Indiana, Minnesota, Michigan, and Wisconsin

Billings Area: Serves Montana and Wyoming

California Area: Serves California and Hawaii

Nashville Area: Serves Eastern United States

Navajo Area: Serves Arizona, New Mexico, and Utah
Oklahoma City Area: Serves Oklahoma, Kansas, and Texas
Phoenix Area: Serves Arizona, California, Nevada, and Utah
Portland Area: Serves Idaho, Oregon, and Washington
Tucson Area: Serves Southern Arizona
CHRs are identified as working in locations (e.g. tribes) within these areas of the regional offices.

Developments in Scope of Practice

In 1981, an evaluation of the Community Health Representative Program produced a number of recommendations for redefining the program's objectives, guidelines, policies and resource allocation. The evaluation recommended the development of regular evaluation standards to ensure the program's goals were being met and standardizing the scope of the CHR program across tribal areas.⁶⁸

In 1983, Congress mandated that IHS establish guidelines, goals, and clear evaluation standards for the CHR program. The IHS produced guidelines and goals for the program that are detailed in Chapter 16 of the Indian Health Manual. They also developed two management tools: the Scope of Work (SOW), for planning purposes, and the CHR Information System II (CHRIS II), for reporting purposes. Although Chapter 16 states that tribal CHR programs will be evaluated on a triennial basis, IHS had neither developed evaluation criteria nor conducted a national evaluation of the program.

As a distinct group, the Alaskan Native Community Health scenario has seen its own developments. In 2001, a study entitled **Community Health Aide Program – Update 2001 – Alaska's Rural Health Care at Risk** was undertaken. The study reviewed the state of affairs of the Community Health Aide Program and considered the at-risk state of Alaska's rural health care system. The following recommendations were made as a result of the study:

1. increase CHA/P positions by 25 per cent (125 positions) at a cost of \$6.1 M
2. increase supervisory positions by 45 per cent (23 positions) at a cost of \$2.3 M
3. increase training center capacity at a cost of \$1.2 M
4. assure program standards at a cost of \$.3 M
5. fund current 'Village-Built Clinics' (VBC) at a cost of \$2.2 M
6. fund projected VBC needs (2003-2005) at a cost of \$2.9 M

With regards to competency development and training in the USA, some recent accomplishments of the CHR program include:

- Successful implementation of the cooperative grant agreement with the National Association of Community Health Representatives (NACHR), to provide improved health services delivery, outreach and health education to Native American persons
- Provision of increased education and outreach services targeting prevention activities including injuries, diabetes, obesity, cardiovascular problems, exercise and lifestyle changes
- Increased activities in and awareness of local, county, regional, and 'Area Emergency Preparedness' efforts and the important partnership role of CHRs in the tribal community to affect those disaster plans
- Planning for the launching of a new CHR website for the Community Health Representative Program that will provide access to a CHR Newsletter. Future

capabilities will permit the downloading of local and regional reports as well as other general information about the CHR program

- In consultation with the Tribal CHR program, a major focus on training. The CHR Program provides three-week CHR Basic training sessions to assist Community Health Representatives in obtaining health and medical education appropriate to the CHR program. The CHR program also provides CHR Refresher training sessions for those CHR staff who have been employed by the local CHR program for more than two years.
- The CHR Program also revised the curriculum for the three-week Basic training manual as well as the CHR Refresher training manual. The manuals were distributed to all CHR tribal programs.
- The Community Health Representative Program continues to maintain a close working relationship with the National Association of Community Health Representatives (NACHR), joining forces to elevate the health status of Native Americans and Alaskan Natives to the highest possible level.

Specific Initiatives and Projects

A number of initiatives have evolved in the United States of America to support the concept of developing scope of practice initiatives for CHR/Ws. For example, two proposals have recently been put forward that might prove very valuable:

1) FIPSE Community of Practice Initiative for Community Health Worker Post-Secondary Programs is an initiative to promote the coordinated development of CHW college-supported educational programs by bringing together experienced developers, educators, expert consultants and employment field site preceptors/mentors/supervisors of college-supported curricula to develop a comprehensive package for adapting institutions across the U.S.⁶⁹

2) The Community Access to Care Community Health Worker Inventory Project, funded by the W.K. Kellogg Foundation and conducted by the Center for Sustainable Health Outreach (CSHO), has as its objectives:

- to build a national database of program sites that incorporate paid or volunteer CHWs, which will help document the work done through those programs
- to build a database of evaluation methods and tools used to evaluate CHW programs
- to create a means of contacting CHWs from across the United States and its territories.⁷⁰

In addition, two other particular projects from the United States of America worthy of a more detailed review include:

1) the 1993 project entitled ***Revitalizing the Community Health Representative Program***. This project addressed the work of Community Health Representatives who are identified as Community Health Workers who work specifically with indigenous Indian populations; and

2) the 1998 project entitled ***The National Community Health Advisor Study***. This project addressed the work of Community Health Advisors who are identified as a grouping of Community Health Workers who work with a variety of culturally distinct populations.

1993 Project⁷¹

In 1993, the Department of Health and Human Services, Office of the Inspector General, pursued a project entitled ***Revitalizing the Community Health Representative Program***. The purpose of the project and the resulting report was to describe factors

which make Community Health Representative (CHR) programs – working specifically with Indian populations - effective in order to revitalize the program. According to respondents, four factors make CHR programs effective.

Factor 1: Agreement on the Role of the CHR

Area and local respondents ranked this factor number one. Their view is that the role of the CHRs at a program must be well defined and understood by everyone involved before any of the other factors can have any impact on the effectiveness of the program.

Factor 2: Integration into the Health Care

A majority of the CHRs ranked this as the factor with the greatest influence on the effectiveness of their program. Other respondents all spoke of the need for CHRs to work closely with health care professionals, especially if they provide medical care to patients. They also said that this is important in the CHRs' role as link to the community.

Factor 3: Tribal Support and Direction

Respondents say that a lack of tribal support and direction may cause a CHR program to deteriorate. It may also lower the morale of the CHRs.

Factor 4: IHS Support and Direction

Respondents believe IHS support has less impact on the effectiveness of CHR programs than other factors. However, they also say that IHS support is needed to make programs strong.

As a result of this report, the Assistant Secretary for Planning and Evaluation (ASPE) agreed that more attention should be paid to the CHR program and that these factors should be considered in any revitalization program.

1998 Project ⁷²

The purpose of the ***National Community Health Advisor Study*** is to provide guidance to policy makers and practitioners on a number of areas that could improve the overall status of the CHA field. The findings presented the following core recommendations:

CHA Core Roles and Competencies

1. Adopt and Refine CHA Roles and Competencies: Disseminate and track use of the study's proposed core roles and competencies and then validate lists with stakeholders.

CHA Evaluation

2. Promote a Comprehensive CHA Research Agenda: Target a research agenda promoting analysis of CHA roles in various settings including Managed Care Organizations (MCOs), and welfare reform. Conduct a multi-site CHA program evaluation.

3. Develop CHA Evaluation Guidelines and Tools: Refine an evaluation framework developed as a part of the Study and create an evaluation "tool kit" for programs.

4. Establish a CHA Evaluation Database: Create a database of evaluators, evaluation tools and findings.

CHA Career Advancement

5. Establish a National CHA Certification: Develop a CHA certification based on refined CHA core roles and competencies; link to other certifications such as those being explored by front-line human services professionals.

6. Create Academic Linkages for CHA Training: Establish academic pathways for CHAs who choose to continue in school and link CHA training to academic credit.

7. Develop CHA Core Curriculum Guidelines and Supervisor Training: Develop and disseminate CHA curriculum guidelines nationally. A related project is the development of CHA supervisor training guidelines.

8. Establish Multi-Program CHA Training and Support Centers: Develop regional and state-based training centers to provide core CHA training complementing program-specific training.

9. Develop Best Practice Guidelines for Programs: Develop guidelines for management and practice for CHA programs in various settings including Managed Care Organizations (MCOs).

CHAs in the Changing Health Care System

10. Educate Managed Care Organizations and State Medicaid Agencies About CHAs: Provide information and training about CHAs to MCO staff and Medicaid administrators who coordinate funding in MCOs.

11. Prepare CHAs and CHA Programs to Compete in the Changing Health System: Educate CHAs about special issues related to member utilization of MCOs; create educational materials and trainings to help CHA programs develop needed infrastructure to work with managed care.

12. Build Sustainability for CHAs and CHA Programs Through Financing Mechanisms and Public Policy: Work to allocate permanent public revenue sources to sustain CHAs through regulatory and public policy change, and work to build support within the private sector for direct services and CHA field infrastructure.

CHA Leadership Development

13. Establish Coordinated Leadership in the CHA Field: Form a national association or similar organization to provide leadership in the CHA field; CHAs should play the key role in governing such an organization. One proposed role for the organization is to coordinate implementation of projects recommended by the study.

Summary of Developments in Scope of Practice

Country	Developments in Scope of Practice	Key Initiatives
Canada	Presently exploring standards and accreditation systems. Have progressed with some initiatives on a provincial/ community/national level. Have support in principle from Health Canada and national organization of CHRs (NIICHO).	- 1998 / 2003 Study by Ship - 2003 Round-table Meeting - 2004 International Comparative Study
Australia	Developed competency standards for CHWs through a 1996 project. Presently working on updated competency standards and system of qualifications. New system of competency standards and qualifications is scheduled to come into effect in 2005.	- 1996: Competency Standards for CHWs - 2004/2005: CHW Competency Standards and Qualifications
New Zealand	Have ideas and enthusiasm regarding the exploration of standards and accreditation initiatives. Have recently developed advocacy/support organizations to promote initiatives.	- hauora.com and te whiringa: advocacy / support organizations
USA	Presently exploring standards and accreditation systems. Have progressed with some initiatives on a regional/ community/national level. Recent research of CHAs (larger group encompassing CHRs – indigenous – and other health workers/advisors).	- 1993: Revitalizing the CHR program - 1998: The National CHA study

Survey Questionnaire Results by Country

The information provided in this section is derived from responses to survey questionnaires that were sent to identified stakeholders in each of the four respective countries (refer to Appendix A for list of stakeholders).

Canada

Category 1: Job Description/Scope of Practice

Original intent of the CHR/W program and its success:

The original intent of the CHR/W program has been liaison work and community health education.

- "After over 40 years of existence, the CHR Program is still considered an important element of the health field and is the best way to reach the grass roots of health in any community. One element of a CHR's job is the home visit and some have said that this is considered one of the strongest aspects of their job as they know the problems of their community and can advocate for the needs of these community members who otherwise are unable to bring their needs to the forefront."
- "In many northern and isolated communities, the turnover of health professionals, and particularly Registered Nurses, is extremely high. The CHR provides the ONLY continuity of care that people in these communities have."

Definition and domains of work describing scope of practice of the CHR/W:

- "The primary role of the CHR/W is the promotion of wellness, the protection of health, and the prevention of injury and illness."
- "(CHR/Ws) assist individuals, families and groups of people in the community to take responsibility for their own health; to work with other health care teams to improve and maintain the spiritual, physical, intellectual, social and emotional well-being of the individuals, families and community."
- "CHR/Ws have become the gateway to the health services in First Nations communities; they are the individuals that educate the non-First Nations professionals on the cultural protocols, the family history of the membership, the political process and other invaluable information related to the community. The CHR/Ws are the people that the community members trust and relate to in terms of health information and services."
- "In most, but not all cases, CHR/Ws are Aboriginal and provide services to Aboriginal populations."

Regarding the domains of work for CHR/Ws, the following indicates responses from the eight Canadian respondents:

8	focus on health education and promotion	8	organize preventative health care
7	act as cultural liaison/advocate for health	8	provide health-related counseling
7	communicate/liaise/translate between health clients and health professionals	7	provide health-related support to clients with diagnosed needs
4	support managerial/workplace demands	3	support management of finances/resources
8	home visitations to clients	4	provide basic medical treatment
1	dispense medications	0	midwifery
5	respond to medical emergencies		

Note: additional domains mentioned include: environmental advocacy, transportation support, assistance with optical and dental services, and crisis counseling.

It was also identified that the work of the Health Worker differed depending on various factors including:

- ☐ rural/isolated area versus urban area
 - ☐ differing tribal/band/community expectations
 - ☐ differing state/provincial/territorial standards
 - ☐ other: different employers
- "The location of a community will definitely determine the domain of work that a CHR will do. The more remote a community is, the more the CHR must be a Jack/Jill-of-all-trades (domains). Being closer to an urban setting allows for more services/resources being accessible therefore there is more of an ability to specialize."
 - "Today, communities undergo a strategic planning session to prioritize local needs and thus identify the community's needs for a CHR/W. These needs may differ even from a neighboring community's, which will identify their priority according to problems identified within the community."
 - "The diversity in the structure of Aboriginal communities (e.g. the governance of communities), leads to CHRs operating in isolation from each other. For example, in BC, there are 204 First Nations communities with 26 tribal groups, 4 major political organizations (the Union of BC Indian Chiefs, the First Nations Summit, the Metis Provincial Council of BC, and the United Native Nations), 20 tribal councils, 109 bands in Health Transfer Agreements (representing 53 per cent of the total number of bands in BC) and there are 67 health centres."
 - "Depending on how a person is employed, they may have a different role and in some cases may take on a different title. For example, provincial health regions employ CHRs to work as members of the Community/Public Health team. Many CHRs are employed in Indian Friendship Centres and other community agencies, working with "healthy families" parenting initiatives or prenatal nutrition programs. In addition to CHRs/CHWs there are other Aboriginal front-line health workers who go by other titles such as Community Wellness Worker and Aboriginal Hospital Liaison worker. There is definitely an overlap in the roles of these workers and the roles of CHRs."

Category 2: Organizational Structure

Category	Organization	Role
National Government Office	First Nations and Inuit Health Branch (FNIHB)	Provides funding based on the Community Workload Increase System (CWIS). Offers funding agreements (e.g. Health Transfer) for CHR (and other) services.
Provincial/State/Territorial Government Office	First Nations Government - Band	Bands may enter into a funding agreement with the FNIHB ("Her Majesty") for CHR services. The objectives of the program are outlined in the funding agreement. In some areas, the Band may delegate delivery of health services to a Health Board or Health Centre and/or CHR director/coordinator.
CHR/W organization	National Indian and Inuit Community Health Representatives Organization (NIICHO)	NIICHO represents "status" Aboriginals. The goal of NIICHO is to improve the quality of health care of First Nations and Inuit people to the standard of health enjoyed by the rest of the population in Canada by supporting the work of its membership (CHRs).
Other	Advocacy/Support organizations: e.g. BC Health Care Associates	There are other associations in some provinces such as Alberta and British Columbia that advocate for CHRs and other health workers.
	CHR provincial coordinator	In Alberta, the FNIHB connects with a regional (provincial) coordinator.
	Brighter Futures and/or Healthy Communities	Sometimes CHRs are employed using different funding (e.g. from Brighter Future)

- "Different provinces/territories/bands have different structures in place for the coordination of CHR/W services. For example, in the province of Alberta, the FNIHB connects with a regional (provincial) CHR coordinator. This coordinator has formal training and experience. The coordinator advises band leadership and health staff of the roles and responsibilities of CHRs; plays an important role in organizing ongoing professional development for CHRs; plays an advocacy role (within both the federal and provincial governments and the communities) on behalf of CHRs; is involved in developing/adopting appropriate health education resource materials for CHRs; supports partnering with other organizations; and supports development of CHR curriculum (e.g. Portage college)."
- "Other CHR/Ws (employed by the provincial health authorities or community agencies rather than Bands) who are not status Aboriginals, have no unifying body to represent them. There is also NO organization that speaks nationally for Metis (mixed-race Aboriginals), nor for CHRs who work off reserve, in urban areas, or who are non-Aboriginal. There is also no representation for Aboriginals who work as front-line health workers, but under a different name, e.g. as family wellness workers, or as diabetes education workers. In the province of British Columbia, the BC Health Care Associates have extended their mandate beyond CHRs to include ALL front-line Aboriginal health workers."

Number/Classification of Health Workers:

Estimates suggest that there are approximately 1,000 CHR/Ws in Canada. The exact numbers are difficult to determine. If CHR/Ws are employees of the Band, then the

Band may use CHR Program funds (CWIS) to pay their CHRs, but they have also used other program funding such as Brighter Futures program and/or Healthy Communities to hire an individual and call them a CHR.

In the table below, the figures reflect the number of CHRs under a funding agreement (as a part of the CHR Settlement Trust). It should be noted that the trust excludes the CHRs employed by: the Northwest Territories, and James Bay in Northern Quebec.

Alberta	110
Atlantic	45
British Columbia	157
Manitoba	108
Ontario	174
Quebec	53
Saskatchewan	98
Yukon	15
TOTAL	760

Professional discipline:

- "Currently, in Canada there are no professional standards or regulations for the roles and responsibilities of CHRs; therefore, no one person or organization is directed with monitoring or disciplining CHRs in this manner."
- "If there is a health regulation broken, professional discipline is most often first managed by the employer. Often (example, in Alberta) CHRs fall under the category "unregulated health care workers" and as such must be under the supervision of a Registered Nurse when providing direct client care; however, the Registered Nurse would have no direct authority to discipline. As such, the Registered Nurse and the employer hold primary accountability, although a CHR could also be sued or criminally charged for negligence."

Communication:

Communication with CHR/Ws occurs in many ways: annual conference, direct mailings (regular newsletter), board meetings, etc. The CHR reports to his/her director through monthly/quarterly/annual submissions and reports. Health Canada receives information on program activities and financial reports from the organization as stipulated in the Health Transfer Agreement.

Recruitment strategies:

Recruitment strategies vary depending on the governance structure that is overseeing the CHR program:

- health fairs
- community leadership or public health nurse/health director
- college advertisement
- personal and informal communication.

Category 3: Budgets and Salaries

Proposal of National Budget	National budgets are controlled by the federal government through Treasury Board regulations and rules. The Community Workload Increase System (CWIS) funding formula is used to establish FNIHB funding. CHRs may be employed by Health Canada, their Band, through a health transfer agency, or alternate means.																		
Source/Allocation of funding	Depending on how the CHR is employed (see above), the sourcing/ allocation may vary: - The Band may sign a funding agreement with "Her Majesty" (federal government/FNIHB) specifically for a CHR; - Sometimes individuals are employed using another funding sources (e.g. from Brighter Future or Healthy Communities) and they are called CHRs																		
Determination of funding structure within communities	"Federally, an envelope of money is identified for CHRs based on the CWIS. To allocate locally, a Contribution Agreement for a CHR is signed between the Band and the federal government." CHRs who work for provincial health regions (funded by the provincial government) are funded through either long-term salaried positions or short-term project positions. Those who work for a community agency tend to be funded on a short-term project position basis.																		
Distribution of funding to Health Workers	From employer (which may vary). "Transfer Agreements have allowed for discretionary powers to determine the rate of a newly employed CHR (as a result, the trend has been for the hourly rate to decrease dramatically with the hiring of untrained CHRs; Band discretionary powers enable them to reprofile surpluses.																		
Consistency of salaries, resources, budgets and benefits	There are large discrepancies; there is variance across communities and across the country.																		
Estimated salaries and benefits	"The allocation of salary is not based on the federal rate of a HS-5 (CHR), but on an historical allocation that is lower than what the federally employed HS-5 receives." <table><tr><td></td><td>Band employed CHR (Manitoba)</td><td>HS-5 (Manitoba)</td></tr><tr><td>1992</td><td>CAN\$12.73/hour</td><td>CAN\$16.54/hour</td></tr><tr><td>2000</td><td>CAN\$16.25/hour</td><td>CAN\$18.99/hour</td></tr></table> The rates for the band-employed CHRs have not evolved. However, if the HS-5 salary scale was used today, the CHR rate, (effective August 5, 2002, source Treasury Board) would be: <table><tr><td>Zone 1</td><td>BC, YK, NU and NT</td><td>CAN\$22.29/hour</td></tr><tr><td>Zone 2</td><td>Atlantic, QC and ON</td><td>CAN\$20.97/hour</td></tr><tr><td>Zone 3</td><td>MB, SK and AB</td><td>CAN\$22.04/hour</td></tr></table>		Band employed CHR (Manitoba)	HS-5 (Manitoba)	1992	CAN\$12.73/hour	CAN\$16.54/hour	2000	CAN\$16.25/hour	CAN\$18.99/hour	Zone 1	BC, YK, NU and NT	CAN\$22.29/hour	Zone 2	Atlantic, QC and ON	CAN\$20.97/hour	Zone 3	MB, SK and AB	CAN\$22.04/hour
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1992	CAN\$12.73/hour	CAN\$16.54/hour																	
2000	CAN\$16.25/hour	CAN\$18.99/hour																	
Zone 1	BC, YK, NU and NT	CAN\$22.29/hour																	
Zone 2	Atlantic, QC and ON	CAN\$20.97/hour																	
Zone 3	MB, SK and AB	CAN\$22.04/hour																	

Category 4: Standards and Accreditation

There is no national system of accreditation for CHR/Ws at this point, but there has been much discussion and many initiatives to explore the possibilities of such developments.

- "When the CHR program was under Medical Services Branch of Health Canada and Agreements were signed with the bands, there was a requirement that the CHR be trained. As time went by, more authority was given to the community and the requirement for a 'trained CHR' relaxed."
- "In July of 2003, a round-table discussion on standards and accreditation for CHR/Ws was coordinated by NIICHRO (and attended by Health Canada, among other stakeholders) as a first step in the initiative to develop and manage national occupational standards of practice and accreditation for CHR/Ws in Aboriginal communities across Canada."
- "In some provinces there is a ... community college diploma program that must be taken to work as a CHR but it is not always enforced at the local level in some communities."
- For example: "In Alberta, the educational institution that educates CHRs has partnered with Alberta Region of Health Canada (FNIHB) to create a provincial Scope of Practice for CHRs. Even so, CHRs remain "unregulated" under provincial health care legislation and as such do not have exclusive right to title, nor are they required to be certified. On the other hand, FNIHB Alberta does require that monies from its contribution agreements with the Bands - that are designated for CHRs - must be used to hire people who have completed formal training as a CHR. Additionally, professional development is offered on an annual basis for past graduates. CHRs are sponsored by their employer to come to our campus for a one-week course to update their skills and knowledge."
- For example: "the Community Health Associates of BC (CHABC), in conjunction with the local community college - Okanagan University college - created a 10-month certificate program titled the Aboriginal Health Worker Training Program."
- "NIICHRO offers National Training Sessions once a year at the Annual General Assembly. This training is non-accredited and the participant is given a Certificate of Participation. The training is topic specific. It does not encompass all aspects of a CHR's job." NIICHRO also offers professional support through publication of its *In Touch* magazine and the development of various resources for its membership (e.g.: Diabetes, HIV/AIDs, Tobacco cessation, etc.)"
- "CHR's roles have evolved in health promotion and prevention, client services, and demand of the CHRs a solid educational foundation complete with competencies that health care workers should possess to work in the communities."
- "There should be a national scope of practice with areas of specialties depending on education and location of employment such as emergency medical interventions for semi- or isolated communities. Education might address the areas of community health promotion and prevention, client care and programming, environmental health, chronic disease, maternal and child health, counselling or mental health, nutrition, diabetes, emergency medical interventions, and patient advocacy as possible concentrations for the diploma. Upon graduation the successful candidates should pass a national CHR examination before being permitted to commence duties as a registered CHR. I think we should have to renew our accreditation and take

updated professional development training on an ongoing basis to keep our competencies current."

- "There should be prior learning assessments for CHR's who have work experience. I do not think that CHR's who have been employed in the last 10 to 15 years should be exempt from the diploma process of education because it has always been mandatory for the CHR to work and attain their diploma through distance education. CHR's employed prior to this time should be grandfathered into the accreditation process because of their wealth of experiences in the field."
- There is a sentiment that higher education may mean that you cannot link as well to the grass-roots/community level of interaction necessary for CHR's.
- "A governing body needs to be adopted that can be impartial and maintain a professional stance. It may be advisable to look at provincial agencies being the central bodies to work with the workers in their respective regions and then merging together on an annual basis to create a national body. (Note: "In Alberta the federal government used to employ area CHR Advisors, however all of these positions have since been declared redundant.")"
- "The governing body could be one that was inclusive of all CHR's/CHWs (and indeed, all front-line cultural health workers – perhaps even those who are non-Aboriginal) who are working in all settings no matter what their status/employer."
- "The Metis Nation, Inuit, Medical Officers of Health, and Federation of Indian Friendship Centres have requested that CHR's be placed in urban and Inuit communities that do not currently have CHR's. As it stands today, off-reserve or urban Aboriginal people do not have the access to CHR's."
- "NIICHO would be an excellent organization to lead the way in the development, implementation and evaluation of a national system of accreditation. They have worked with CHR's from across the nation on a successful wage parity class action lawsuit on behalf of the membership and have gained the respect of CHR's nationwide. Over the years, NIICHO has been instrumental in the professional development of CHR's in Canada. NIICHO already has the base line evidence and knowledge to lead the way for a national system of accreditation for CHR's."

Category 5: Professional Relationships

- "In general, CHR's have said that they feel their opinion is not respected. It is like the other health professionals have little regard for what the CHR says or does. With accreditation, CHR's will be better recognized... Also having scope of practice determined, health workers will know each other's boundaries and ensure a better work environment."
- "In my community, based on my level of education and work experience, other health care professionals treat me with a high degree of respect. I have a high skill set and willingness to learn more advanced skills to benefit the clients in my semi-remote community. Others see my role in the community as a great assist and a complement to the services that they provide their patients."

- "If there is no system/standard, then the relationships would remain unchanged and the clients would be at a disadvantage. For instance, previously it was nothing for a CHR to dispense OTC medications, change dressings, read TB results, or take a glucometer reading; now many nurses and physicians are second-guessing the roles of CHRs because of regulations and legislations, especially liability issues."
- "My experience is that the majority of health care professionals have never heard of the CHR role, or if they have, their understanding of it is relatively poor. On the other hand, I also know that those of us who have worked extensively with CHRs have a great deal of respect for the importance of the CHR role."
- "The health scenario would be enhanced with accreditation/standards because expectations, roles and responsibilities would be delineated and standardized across the country. We would be making the most effective use of each and every member of the community health team."
- "With systems of accreditation/standards in place, the relationship may improve or the process may ostracize the CHR and CHW from the non-First Nations professionals."

Category 6: Challenges and Best Practices

Key challenges:

- "lack of:
 - ongoing standardized training and upgrading of skills
 - recognition by the formal health care system and hence underutilization of this group of workers; legitimacy of the CHR role is always being called into question, i.e., CHR is not perceived as being a "viable" or legitimate health career by other health care professionals
 - portability/mobility across geographic areas due to lack of national standards and accreditation
 - supervision; unhealthy workplace environments
 - networking opportunities and opportunities for career advancement
 - standardized and fair salaries"
- "Confusion that gets created by the myriad of front-line cultural health workers, who have a variety of names, job descriptions, and training (yet who also share the same basic set of core competencies)"
- "CHRs who have received ad hoc, on-the-job training receive no credit for their knowledge and skills when they decide to further their education."
- "The need to organize provincial associations to lobby for recognition as unique health care providers, with mandatory registration and exclusive right to title (I would suggest this needs to be done provincially on the basis that legislation governing health care providers falls within the provincial mandate; also, this way CHRs who work for employers other than the Bands or the federal government would also be covered)."

- "Access to education is limited for those who wish to attend a college certificate program; there is a need for more flexible delivery, possibly combining distance delivery (either print-based or online) with face-to-face delivery close to the student's home."
- "Excess demands to meet community needs (too many duties, not enough time)."
- "Some CHRs may lack the capacity to achieve accreditation. As front-line workers, their main function is in dealing with the people in their community. They have great people skills but may have poor writing or math skills; this would affect them in getting accredited. Thus we could have fewer CHRs when actually there is a need to increase the number of CHRs."
- "NIICHRO, in collaboration with stakeholders, could develop and implement a system of accreditation, but the adoption of such a program still comes down to the Band. Bands could decide not to participate in the initiative. Even with the support of the political will of the Assembly of First Nations, a Chief and Council could potentially opt out as is their right."

Best practices:

- "There is widespread recognition that CHR/Ws play an important role in health care, health education, and health promotion in First Nations and Inuit communities. The CHR is frequently the essential provider of health services, particularly in northern, remote, and/or isolated communities where there are no other health professionals or where retaining nurses has proven difficult."
- "Both national and regional Aboriginal associations have supported the expansion and enrichment of the CHR program over the years, including supporting the concept of developing national occupational standards and accredited training for CHRs."
- "Keeping in mind the need for best practices in all areas of the health care system, it is imperative for the CHR profession to have a scope of practice and professional standards that will be implemented and evaluated and that includes ongoing certification and methods of discipline for professional misconduct. This would ensure the clients are receiving a high quality of services across the nation and also provide security and guidance for the people working in the profession."
- "After over 40 years of existence, the CHR Program is still considered an important element of the health field and is the best way to reach the grass roots of health in any community. One element of a CHR's job is the home visit and some have said that this is considered one of the strongest aspects of their job as they know the problems of their community and can advocate for the needs of these community members who otherwise are unable to bring their needs to the forefront."
- "In many northern and isolated communities the turnover of health professionals, and particularly Registered Nurses, is extremely high. The CHR provides the ONLY continuity of care that people in these communities have."

Australia

Category 1: Job Description/Scope of Practice

Original intent of the Aboriginal and Torres Strait Islander Health Worker Program and success:

- "... to create a conduit between non-indigenous health professionals and indigenous patients."
- "... (to act as) liaisons/cultural brokers between the community and the health service."

While some respondents indicate that the program has been successful, some also suggest that the "the original intent has been overtaken by the desire to have Health Workers carry out advanced clinical practice."

Definition and domains of work describing scope of practice of the Aboriginal and Torres Strait Islander Health Worker:

"An Aboriginal or Torres Strait Islander Health Worker is an Aboriginal or Torres Strait Islander person who holds a recognized industry qualification and who works within a holistic primary health care framework as determined by the local Aboriginal or Torres Strait Islander community to achieve better health outcomes for Aboriginal or Torres Strait Islander individual/families and their communities."

The domains of work include:

- | | |
|---|---|
| ☐ focus on health education and promotion | ☐ organize preventative health care |
| ☐ act as cultural liaison/advocate for health | ☐ provide health-related counseling |
| ☐ communicate/liaise/translate between health clients and health professionals | ☐ provide health-related support to clients with diagnosed needs |
| ☐ support managerial/workplace demands | ☐ support management of finances/resources |
| ☐ home visitations to clients | ☐ provide basic medical treatment |
| ☐ dispense medications | ☐ midwifery |
| ☐ respond to medical emergencies | |

Additionally, it was identified that the work of the Health Worker differed depending on different factors including:

- ☐ rural/isolated area versus urban area
 - ☐ differing tribal/band expectations
 - ☐ if work is undertaken by Health Workers in State Health Services or Community-controlled Health Services
-
- "Remote practitioners need the broad-based skills including clinical invasive practices."
 - "The urban areas draw more on liaison and education skills."

Category 2: Organizational Structure

Category	Organization	Role
National Government Office	The Commonwealth Office of Aboriginal and Torres Islander Health (OATSIH)	Maintains the role of the funding body for all Community-controlled Health Agencies; provides funding for the non-government health organizations (including non-governmental Health Workers)
Provincial/State/Territorial Government Office	State/Territory Health Departments e.g. Northern Territory Government, Department of Health and Community Services	Employs Aboriginal Health Workers to carry out work in remote, regional and urban settings; provides funding for the Aboriginal Health Workers that work within the government structures
CHR/W organization	National Association of Community Controlled Health (NACCHO) State/Territory Groups: e.g. the Professional Aboriginal Health Worker Association of South Australia (PAHWASA.)	Advocacy and lobby group
Other	Unions e.g. Australian Workers Union (AWU) Health Services Union of Australia	Some Health Workers are members of unions

NACCHO is the peak body for Aboriginal and Torres Strait Islander Health Services. Aboriginal and Torres Strait Islander Health Workers are employed by Aboriginal and Torres Strait Islander Health Services, which are members of NACCHO. State/Territory Health Departments are responsible for these employees.

In most states/territories, Health Workers are not required to be members of a professional or representative CHR/W organization. The exception is in South Australia.

Number/classification of Health Workers:

Surveys estimate that there are 1,400 Aboriginal and Torres Strait Islander Health Workers. Nationally, Aboriginal Health Workers are employed in a number of different ways. For example, they can be classified as non-governmental or governmental employees.

Professional discipline:

Situations requiring professional discipline are led first by the employer and then referred to the governing body (e.g. Aboriginal Community-Controlled Health Service or the State/Territory Health Department for which they work).

Recruitment strategies:

Recruitment strategies work on a number of levels:

- "There are the informal word-of-mouth network activities which operate at remote community and regional levels."

- "In some remote areas, communities nominate Health Workers."
- "At higher, more formal levels, advertisements are placed in Northern Territory and Australian national mainstream newspapers."
- "There is a national Indigenous Health Workforce Strategy which has just been endorsed which has projected outcomes for building the workforce including Aboriginal Health Workers."

Category 3: Budgets and Salaries

Proposal of National Budget	Office of Aboriginal and Torres Strait Islander Health (OATSIH)
Source/Allocation of funding at the national level	OATSIH funds Aboriginal and Torres Strait Islander Health Services with a global budget.
Determination of funding structure within communities	"Officially, Aboriginal Health Workers are paid in accordance with an industry award, which sets out the remuneration, conditions and benefits for its workers. This is complied with for government employees. Community-controlled health centres are covered by the same award, but particularly in remote settings, these conditions and levels of pay are often ignored."
Distribution of funding to Health Workers	Global budgets are provided to Aboriginal and Torres Strait Islander Health Services by the OATSIH and individual services pay the wages of the Aboriginal and Torres Strait Islander Health Workers.
Consistency of salaries, resources, budgets and benefits	There is no national consistency of salaries, resources, budgets and benefits for Aboriginal Health Workers. There are differences between states and territories.
Estimated salaries and benefits	Average: AUD\$30,000/year Range: AUD\$20,000 - \$50,000/year Benefits negotiated between employee/employer to suit locality and needs.

Category 4: Standards and Accreditation

- There is no national system of accreditation for Health Workers at this point, but: "...the Aboriginal and Torres Strait Islander Health Worker National Competencies and Qualifications will be introduced in 2005. This will provide the basis for standards for Aboriginal and Torres Strait Islander Health Workers." It is proposed that OATSIH, Aboriginal and Torres Strait Islander Health Services, NACCHO and State/Territory Health Departments will be key organizations to initiating and overseeing the program. Similarly, employers will be charged with facilitating ongoing supervision, support and education.
- "The introduction of Aboriginal and Torres Strait Islander Health Workers Competencies and Qualifications will standardize Aboriginal and Torres Strait Islander Health Worker training and recognized qualifications. It will also help to professionalize the sector as only those doing recognized training will be able to call themselves Aboriginal and/or Torres Strait Islander Health Workers."
- "The new system will have some limitations and may reduce the capacity of people in remote areas with poor literacy from becoming Aboriginal and Torres Strait

Islander Health Workers. However the proposal is to have a basic level of training with a qualification like Community Development that will enable these people to participate in Primary Health Care."

- "Currently there is accredited training for Aboriginal Health Workers available, although only three jurisdictions access this training framework. The Northern Territory, Queensland and Western Australia all deliver accredited training and provide training support mechanisms."
- "Generally, certificates III and IV are accepted as the entry to point to become an Aboriginal and/or Torres Strait Islander Health Worker, although this is not constant across the country. Consistency will come with the National Competencies and Qualifications."

Category 5: Professional Relationships

- "In remote clinics and other settings, Aboriginal Health Workers are supervised by Registered Nurses but they carry out activities which are more senior and complex than enrolled nurses do."
- "Unless the qualifications of Aboriginal Health Workers are brought into the same training framework as other health workers', they will exist in isolation and these workers will continue to be marginalized as they are currently."
- "The Aboriginal and Torres Strait Islander Health Worker accreditation system will professionalize the sector and provide improved standing for Aboriginal and Torres Strait Islander Health Workers."

Category 6: Challenges and Best Practices

- "The key challenges are working in an environment which has some of the worst indigenous health outcomes other than the Third World. Indigenous health outcomes in remote settings have been described as worse than some Third World countries. Training as Aboriginal Health Workers is complex and exacerbated by low literacy and numeracy levels and inadequate housing and essential services infrastructure."
- "There is a difficulty around the way in which the role of Aboriginal Health Workers has evolved. Initially, the workers were supposed to be cultural brokers and cultural interpreters. Now that role seems to have diminished and they are being trained to be Aboriginal equivalents of nurses, without the full scope of learning, any acknowledgement of the role or place in the hierarchical structure. There is certainly no robust data that supports their role having made an impact on primary health levels in remote settings."
- "Key challenges include professionalizing the sector and establishing associations."
- "The Kimberley Aboriginal Medical Service (an Aboriginal community-controlled organization in far northwestern Australia) has a training unit with articulated courses from Certificate III through to Advanced Diploma."

New Zealand

Category 1: Job Description/Scope of Practice

Original intent of the Māori Community Health Worker

- "The original intent of the MCHW program in New Zealand (Aotearoa) was to address the health needs of Māori families in a manner that allowed health promotion and education messages to get across to Māori families in a peculiarly Māori way."
- "As a response to the poor health status of Māori people that has evolved over time (largely as a result of colonization), the government of New Zealand funded small pilot projects with Māori Health Providers to attempt to address the issues. As a result, many other Māori Health Providers were established, and their contracts with the government reflected and enabled Māori to offer services that Māori clients could access."
- "The MCHW has been funded as a part of the Māori Health Provider program for the last two decades. However, there are other Māori organizations such as the Women's Health League, established in 1937, that were doing the work of the MCHW long before it was funded by government. The Māori Women's Welfare League was established in 1951 and that too was an organization that did voluntary work in the health sector to address the poor health of Māori. It is interesting to note that the evolving definition of the MCHW in recent years is one that does not include voluntary workers."
- "With regards to the success of the Māori Community Health Worker, there is anecdotal evidence that links the role of the MCHW to the rise in life expectancy rates of Māori."
- "The MCHW role in Rotorua has decreased the amount of admissions into the Children's Ward of the Public Hospital and the following outcomes have been achieved also:
 - higher uptake of immunizations among Māori children, twice the national average uptake;
 - 80 per cent of homes smoke free at birth of baby; and
 - 60 per cent of pregnant mothers who are clients of MCHW either refrain from or reduce smoking in pregnancy."

Definition and domains of work describing scope of practice of the Māori Community Health Worker:

- "The original intent of the role of MCHW and the scope of their work changed and widened as the needs of Māori families increased."
- "The extra workloads and demands on the MCHW have largely gone unchecked and the role of the MCHW has become confusing. The role of the MCHW is largely about addressing the needs of Māori people, while still working within the boundaries of their job descriptions, the policies and procedures of their workplace, and relevant statutes and government strategies."

- "A Māori Community Health Worker (MCHW) has yet to be formally defined and described. Te Whiringa is currently going through the process of surveying MCHWs for their belief of how the role should be defined."
- "Informally, the MCHW is defined as a person of tangata whenua status (i.e., has Māori ancestry), who works in the Māori community for Māori clients who have accessed health services. The MCHW is not a medical practitioner or clinician and does not diagnose illness, treat disease or administer drugs. Rather, the MCHW facilitates and maintains well-being from a holistic perspective within a whānau (family, immediate and/or extended)."

The following domains of work define / describe the 'scope of practice' of an MCHW:

- ☐ focus on health education and promotion
- ☐ organize preventative health care
- ☐ act as cultural liaison/advocate for health
- ☐ provide health-related counseling from an holistic and cultural perspective
- ☐ communicate/liaise/translate between client and rest of health team
- ☐ provide health-related support and information to clients with diagnosed needs
- ☐ support managerial/workplace demands
- ☐ home visitations to clients

The following domains DO NOT define / describe the 'scope of practice' of the MCHW:

- ☐ support management of finances/resources
- ☐ provide basic medical treatment
- ☐ dispense medications
- ☐ midwifery
- ☐ respond to medical emergencies

Additionally, responses indicated that the following domains also define / describe the 'scope of practice' of the MCHW:

- ☐ Provide support for the whole family
- ☐ Provide social services and work with care and protection of children issues
- ☐ Provide budget advice, housing and social welfare advice
- ☐ Provide parenting advice and 'mother craft' skills advice
- ☐ Provide transport to appointments
- ☐ Provide facilitation services to access GPs, nurses, hospitals

Surveys suggested that the work of the Health Worker differed depending on different factors including:

- ☐ rural/isolated area versus urban area
- ☐ differing state/provincial/territorial standards
- ☐ differing tribal/band expectations

- "The domains of work differ depending on different factors. These are normally determined at the contractual level with the Ministry of Health and depend on whether the worker is part of a Māori or non-Māori Health Provider."
- "Māori Health Providers demand that Māori-specific health knowledge and ways of working be used appropriately alongside State outcomes and outputs. Tribal Health Authorities have different expectations for their workers – they demand that they are a tribal worker rather than a worker who happens to be tribal."

- "Rural MCHWs are known to have to do work that is not normally within their domain. There are instances where the MCHW has had to deliver babies, administer pain relief and medication and provide medical treatment to Māori clients. This is not however within the normally defined scope of their practice and is not considered safe practice at all."

Category 2: Organizational Structure

Category	Organization	Role
National Government Office	Ministry of Health	Funds MCHWs through their employer
CHR/W organization	Te Whiringa	Established as a charitable trust in September 2003 for the purpose of receiving funding from the Ministry of Health to achieve the following outcomes: 1. establish a national association for MCHWs 2. define the role of the MCHW 3. develop competencies for the MCHW
Other	Employers	Since there is no national governing body, employers of MCHWs act as such and are responsible to monitor MCHWs
	Hauora.com	Maori-led initiative/organization that provides advocacy/support to Maori health professionals/workers.

Number/classification of Health Workers:

"The number of MCHWs cannot be determined since there is neither a specific 'scope of practice' description nor a governing body."

Professional discipline and communication:

- "Te Whiringa holds an annual national hui (meeting) and sends newsletters to people who identify themselves as MCHWs and who attended the previous national hui."
- "The Ministry of Health funds Te Whiringa to hold the national hui, and to hold regional hui (gatherings of many people in one place for the purpose of discussing a few defined issues)."
- "There are informal and optional forums that are held in various regions and there are also various training programs that provide information to MCHWs."
- "Employers are responsible to communicate with the MCHW. The employer is bound to provide a safe workplace for the MCHW, to monitor their boundaries and to maintain compliance with statutory provisions and contracts."

- "There is no mandatory requirement for MCHWs to receive clinical or cultural supervision, however many MCHWs receive this."
- "There is no mandatory requirement to be formally qualified or to be accredited as an MCHW and there is no mandatory requirement to belong to a national association (one is still being set up)."

Recruitment strategies:

"Since the role of the MCHW is loosely defined, and since there is no set MCHW contract, it is hard to accurately define the recruitment strategies for the MCHW workforce as a whole, however in individual organizations, the following recruitment strategies are employed:

- Training program that leads to membership network that leads to employment in some instances
- Word of mouth
- Formal advertising in the local newspapers
- E-mails between networks and organizations advertising positions available
- Tribal and sub-tribe recruitment processes
- Employment agencies."

Category 3: Budgets and Salaries

Proposal of National Budget	There is no national budget for MCHWs – the employer will apply for a contract to employ a MCHW in their area.
Source/allocation of funding at the national level	The employer.
Determination of funding structure within communities	Established by an individual employment contract that is negotiated between the employer and the MCHW; the contract is not based on any defined pay scale or rate that is set as a result of competencies of the MCHW.
Consistency of salaries, resources, budgets and benefits	There is no national consistency of salaries, resources, budgets and benefits for MCHWs.
Estimated salaries and benefits	Salary – not set Training, support and supervision vary. Compensation for mileage if own car is in use, or work vehicle for work purposes

Category 4: Standards and Accreditation

- "At present there is no national system of standards and accreditation for MCHWs, but the Ministry of Health is in consultation with Te Whiringa and other interested stakeholders."
- "While there is no national system, various sectors have funded program (e.g. Child and Family Health)."

- "The introduction of a Māori Community Health Worker national system of standards and accreditation will change the workforce and will strengthen the ability of workers to offer services to Māori people."
- "If a national system of accreditation is created, it must recognize the localized needs of each community including Māori cultural values; if not, then it will likely cause Māori families to further retract from accessing health services."
- "Clinicians and health professionals will value the higher education of the MCHW and this will have a positive effect on the MCHWs in communities."
- "Some training that presently exists for MCHWs includes:
 - Level 4 certificate in Hauora Ahu Whenua Whānau Tamariki – Wintec
 - Level 4 certificate in Hauora – Mauri Ora Associates
 - Level 4 Certificate in Health Promotion – MIT
 - Plunket Training
 - Te Korowai Aroha Training
 - Ringa Atawhai Training
 - EIT Certificate
 - MIT Certificate
 - Arotech Certificate
 - Te Ngaru Learning Systems
 - Smoking Cessation Training
 - Ministry of Education Training for CHWs
 - MOH Project Training"

Category 5: Professional Relationships

- "Typically MCHWs are seen to be 'at the bottom of the heap'. MCHWs are not required to have set qualifications and therefore they are not considered professional by other medical professionals."
- "Supported to an extent in terms of value of role but often not viewed as part of the health team. Often the MCHW is referred to where there are social issues and the holistic approach to health service is not always embraced."
- "The MCHW is often seen as the advocate for the extended family and the interpreter and conduit between the health sector and the family."
- "It would be good for other health professionals to understand and appreciate the defined role of the MCHW; this might come with a system of standards and accreditation."

Category 6: Challenges and Best Practices

Key challenges

- "Lack of:
 - pay parity
 - coordinated approach for MCHWs in terms of career pathways, recruitment, attrition and retention
 - understanding by other health professionals of MCHWs' grass-roots work

- knowledge around cultural needs and norms that need to be at the forefront of competency development
- respect for MCHWs and their role by the health professionals"

Best practices

- "MCHWs are culturally sound/connected to the Māori people."
- "MCHWs communicate well with the Māori people."
- "MCHWs advocate for the Māori people."

United States of America

Category 1: Job Description/Scope of Practice

Original intent of the Community Health Representative/Worker Program:

- "The original intent of the CHR/W program was to identify local community members who could play a bridging role between the health system and communities."
- "The original model was based on a volunteer community health advisor idea."
- "The CHR/W program has been successful, but it is underfunded"
- "Although success can be defined differently, I believe that the CHW programs in the U.S. are successful, if they truly have community health workers integrated into the decision making, planning, implementation, and evaluation of the program."

Definition and domains of work describing scope of practice of CHR/Ws:

- "At this time, work is being done with CHWs across the nation in developing a national CHW definition. Efforts are being initiated by the Center for Sustainable Health Outreach (CSHO) and work is also being done with the CHW Special Primary Interest Group (SPIG) of the American Public Health Association (APHA) to develop a CHW definition."
- For now: "Community Health Workers provide culturally, linguistically, and otherwise appropriate outreach, prevention, intervention, and treatment services, which are based in, and reflect, the value systems of the community."

While survey responses varied, each of these domains of work was identified as describing the scope of practice of the CHR/W :

- | | |
|---|---|
| ☐ focus on health education and promotion | ☐ organize preventative health care |
| ☐ act as cultural liaison/advocate for health | ☐ provide health-related counseling |
| ☐ communicate/liaise/translate between health clients and health professionals | ☐ provide health-related support to clients with diagnosed needs |
| ☐ support managerial/workplace demands | ☐ support management of finances/resources |
| ☐ home visitations to clients | ☐ provide basic medical treatment |
| ☐ dispense medications | ☐ midwifery |
| ☐ respond to medical emergencies | |

In a national study of CHR/Ws, the following CHR/W roles were identified (N. Wiggins in University of Arizona, 1998):

cultural mediation	health education
ensuring access to care	informal counseling and social support
individual and community advocacy	provision of direct service
individual and community capacity building	

Additionally, it was identified that the work of the Health Worker differed depending on different factors. For example, it was suggested that "tribal CHRs appear to have more ability to provide direct medical services than non-tribal CHRs." As well, it was indicated that the scope of practice for CHR/Ws depends on "agency, location, funding, sources, etc."

Category 2: Organizational Structure

Category	Organization	Role
National Government Office	Indian Health Service (IHS)	Upholds the federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.
Provincial/State/Territorial Government Office	There are 12 IHS administrative units, called Area Offices, that represent the various states/areas of the United States of America	Aberdeen Area Alaska Area Albuquerque Area Bemidji Area Billings Area California Area Nashville Area Navajo Area Oklahoma City Area Phoenix Area Portland Area Tucson Area
CHR/W organization	National Association of Community Health Representatives (NACHR) Others: Center for Sustainable Health Outreach (CSHO), CHW Special Primary Interest Group (SPIG), etc.	Advocacy and lobby group
Other	There are a number of state, local, tribal and community organizations that support CHR/Ws and their distinct communities.	Advocacy

Number/classification of Health Workers:

"A study is soon to be launched to assess accurate numbers. However, survey estimates in 1998 indicated that there were approximately 1,600 CHRs (CHWs working in Indian communities) and 12,500 CHWs in total (both paid and volunteer)."

"Up until two years ago, CHRs had more positions within the IHS; there has been a downsizing because of financial constraints."

Professional discipline and communication:

- "CHWs are generally governed and disciplined according to the organization that employs them."
- "Most CHW organizations have advisory committees that help advise the governing bodies"
- "The IHS is an agency within the Department of Health and Human Services that operates a comprehensive health service delivery system for approximately 1.6 million of the nation's estimated 2.6 million American Indians and Alaska Natives. Its annual appropriation is approximately \$3.5 billion. The IHS strives for maximum tribal involvement in meeting the needs of its service population. There are more than 560 federally recognized tribes in the United States. Their members live mainly on reservations and in rural communities in 35 states, mostly in the western U.S. and Alaska. Federally recognized American Indian tribes and Alaska Native corporations enjoy a government-to-government relationship with the United States of America."

Recruitment strategies:

- "Recruitment strategies vary by programs (e.g., word of mouth, leaders from within tribe, leaders in clinic, etc.). However, most community health workers are recruited from the populations they serve because they reflect the cultural, linguistic, socioeconomic, religious, and ethnic values of the populations they serve."

Category 3: Budgets and Salaries

Proposal of National Budget	IHS through the Department of Health and Human Resources (approved by presidential office). In 2004, \$51 million were enacted. Additional budgets may come from other sources. For example, through the CSHO Access to Care Community Health Worker Inventory Project.
Source/allocation of funding at the national level	Varies according to the type/scope of services and the organization.
Determination of funding structure within communities	Varies according to the type/scope of services, regional location and the organization.
Distribution of funding to Health Workers	By employer.
Consistency of salaries, resources, budgets and benefits	There is no national consistency of salaries, resources, budgets and benefits for Aboriginal Health Workers. There are differences between states and territories.
Estimated salaries and benefits	Estimated Range: US\$15,000 - \$42,000/year Variance depends on location, organizational support and the philosophy of the program. In some areas, the work of CHWs is voluntary.

Note: It was identified that the CHR program receives only 48 per cent of the level of funding that it needs; surplus funding comes from private billing. In 2004, approximately \$51 million were enacted to support the CHR program which offered 2,173,600 services tribally.

Category 4: Standards and Accreditation

- "There is no national system of standards and accreditation for CHR/Ws, but some states/areas are attempting to establish standardization and credentialing bodies (e.g. Texas and Ohio)."
- While there is no national system, "the National Community Health Advisor Study has chronicled core roles and competencies for CHAs, but they are not mandated by any credentialing body nor are all of the roles and competencies required."
- "Some states have made significant moves to undertake this step. However, many of these steps have come under criticism because Community Health Workers have not been involved in the decision-making process for credentialing and/or certification. While a national system of accreditation has been discussed, the dialogue for and against such a system still needs further investigation."
- "Because there is not a national body that governs Community Health Workers, identifying an agency (that would be responsible to initiate and oversee such a system of standards and accreditation) would be premature. However, any agency that credentials or accredits Community Health Workers must be made up of Community Health Workers and have Community Health Workers in positions of power."
- "... a national system of accreditation would help standardize the profession and create career opportunities for the profession. Salaries, benefits and support mechanisms would also be strengthened, and standards/protocols would be in place. Another benefit is that Community Health Workers would have a stronger collective voice in advocating for their needs and their profession."
- "However, many Community Health Workers may be excluded from the profession because they do not meet the requirements. Also, some Community Health Workers may feel restricted in their ability to do their job because protocols of care are rigid. Community Health Workers often pride themselves on their ability to adapt and meet the needs of their communities. This is one of their strengths."
- There is "concern about how to be inclusive of the different groups from different areas."
- There is "concern that a national system of accreditation might create a barrier of distance with some at-risk communities. There are some Community Health Workers who can gain entry into communities based solely on who they are. If they were accredited, it might take away the relationship the Community Health Worker has with the community."
- With regards to curriculum development and training/education, it is suspected that "many organizations will develop training/educational programs to meet the needs of

the specific programs. Others will incorporate models that are currently in existence and adapt them to meet the needs of their programs. Still others will hire groups/consultants/programs to come in and train their workers."

- "Ongoing supervision, support, and education are important topics to many Community Health Workers."

Category 5: Professional Relationships

- "Limited recognition by other professionals – particularly outside of Indian Health Services."
- "The relationship with other health and social services professions certainly depends on the location and type of program. Overall, Community Health Workers are essential to any program. However, many Community Health Workers are not respected as essential, integral members of the health care team. They are often called paraprofessionals, alluding to the idea that they are not real health professionals. They are the first to be cut when budget cuts are made, and they are often criticized for not conforming to the medical paradigm. Because community health does not happen between the hours of 9 am – 5 pm, many health professionals do not understand who Community Health Workers are, what they do, and how important they are to the success of a program."
- "Community Health Workers' skills are often devalued. Many programs will "use or utilize" Community Health Workers, and they do exactly that. Some programs feel that only the health professional can make presentations or represent the organization to stakeholders, but they expect Community Health Workers to deliver on all other aspects. Community Health Workers are often not invited to deliver presentations at state and national conferences, even though they are the ones most knowledgeable about the program."
- "On the other hand, many Community Health Workers work well with health professionals. Most Community Health Workers have the community's wellness at heart, and they will try to accomplish what is in the best interest of the community."
- "... a system of accreditation might be beneficial to Community Health Workers because it will define who CHR/Ws are and what they do. This will allow for the Community Health Worker profession to become standardized, and their scope of knowledge and skills would become valued."
- "On the other hand, many Community Health Workers do the jobs of some health educators, nurses, and social workers, and this might threaten some of those professions. It could create additional strife."

Category 6: Challenges and Best Practices

Key challenges

- "Most Community Health Workers are overworked and underpaid. Many Community Health Workers live in the very populations that are labeled as underserved and low-income."

- "Education, career ladders, and credentialing are key challenges. While many Community Health Workers receive certificates from training that they have completed, these certificates often have no monetary compensation for completion and cannot be transferred from program to program."
- "The roles and competencies of Community Health Workers are misunderstood and undervalued. Community Health Workers are not valued as health professionals. They are seen as paraprofessionals. Many people do not understand who Community Health Workers are and what they do."
- "Some Community Health Workers are paid, and some are volunteers. A clear delineation of the role between both paid and volunteer Community Health Workers is needed to strengthen program practice."
- "Community Health Workers have not come together as one entity to advocate for their profession."

Best practices

- "College programs in San Fran and Arizona"
- "At the Center for Sustainable Health Outreach, there are several model programs that are considered best practices:
 - The Community Health Advisor Network (CHAN) program promotes individual self-reliance by empowering volunteer natural helpers to solve health and wellness problems. This program is a volunteer-based Community Health Worker program and is unique because it is non-prescriptive in nature. The community decide their health priority issues, and they determine their steps to action and solutions to the issues.
 - The Maternal Infant Health Outreach Worker (MIHOW) program is a community-based home visiting program aimed at improving family health and early childhood development for low-income families.
 - Deep South Network for Cancer Control (DSNCC) is an adaptation of the Community Health Advisor Network Program. While CHAN is non-prescriptive health promotion, DSNCC is focused on a specific disease, cancer."
- Note: The Centers for Disease Control and Prevention have compiled an annotated bibliography of Community Health Worker programs.

Survey Questionnaire Results: Comparative Summary

Category 1: Job Description and Scope of Practice

Canada	• The CHR/W is "... the best way to reach the grass roots of health in any community." • "One element of a CHR's job is the home visit they know the problems of their community and can advocate for the needs..." • "In many northern and isolated communities, the turnover of health professionals, and particularly Registered Nurses, is extremely high. The CHR provides the ONLY continuity of care that people in these communities have." • "The primary role of the CHR/W is the promotion of wellness, the protection of health, and the prevention of injury and illness." • "(CHR/Ws) assist individuals, families and groups of people in the community to take responsibility for their own health; to work with other health care teams to improve and maintain the spiritual, physical, intellectual, social and emotional well-being of the individuals, families and community." • "CHR/Ws have become the gateway to the health services in First Nations communities; they are the individuals that educate the non-First Nations professionals on the cultural protocols, the family history of the membership, the political process and other invaluable information related to the community. The CHR/Ws are the people that the community members trust and relate to in terms of health information and services."
Australia	• Original intent was "... to create a conduit between non-indigenous health professionals and indigenous patients" and "... (to act as) liaisons/cultural brokers between the community and the health service." • "... the original intent has been overtaken by the desire to have Health Workers carry out advanced clinical practice." • "An Aboriginal or Torres Strait Islander Health Worker is an Aboriginal or Torres Strait Islander person who holds a recognized industry qualification and who works within a holistic primary health care framework as determined by the local community to achieve better health outcomes for Aboriginal or Torres Strait Islander individuals/families and their communities."
New Zealand	• "The original intent of the Maori Community Health Worker (MCHW) program in New Zealand was to address the health needs of Māori families in a manner that allowed health promotion and education messages to get across to Māori families..." • "The role of the MCHW is largely about addressing the needs of Māori people, while still working within the boundaries of their job descriptions, the policies and procedures of their workplace, and relevant statutes and government strategies." • "Informally, the MCHW is defined in as a person of tangata whenua status (e.g. has Māori ancestry), who works in the Māori community for Māori clients who have accessed health services. The MCHW is not a medical practitioner or clinician and does not diagnose illness, treat disease or administer drugs. Rather, the MCHW facilitates and maintains well-being from a holistic perspective within a whanau (family, immediate and/or extended)."
United States	• "The original intent of the CHR/W program was to identify local community members who could play a bridging role between the health system and communities." "The original model was based on a volunteer community health advisor idea." • "At this time, work is being done with CHWs across the nation in developing a national CHW definition." • For now: "Community Health Workers provide culturally, linguistically, and otherwise appropriate outreach, prevention, intervention, and treatment services, which are based in, and reflect, the value systems of the community."

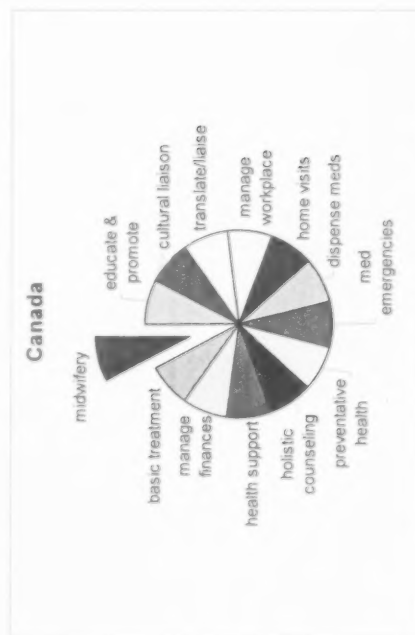
CHARTS: SCOPE OF PRACTICE (DOMAINS OF WORK)

Stakeholders were asked to define/describe the 'scope of practice' of a CHRW in their nation by indicating the appropriate domains of work from the following list:

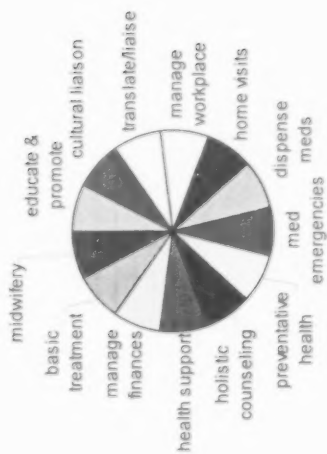
- ☐ focus on health education and promotion
- ☐ act as cultural liaison/advocate for health
- ☐ communicate/liaise/translate between health clients and health professionals
- ☐ support managerial/workplace demands
- ☐ home visitations to clients
- ☐ dispense medications
- ☐ respond to medical emergencies
- ☐ organize preventative health care
- ☐ provide health-related counseling
- ☐ provide health-related support to clients with diagnosed needs
- ☐ support management of finances/resources
- ☐ provide basic medical treatment
- ☐ midwifery

The following pie charts represent the responses given by each country regarding the different domains. Since a small number of stakeholders were surveyed from each country, the charts indicate that:

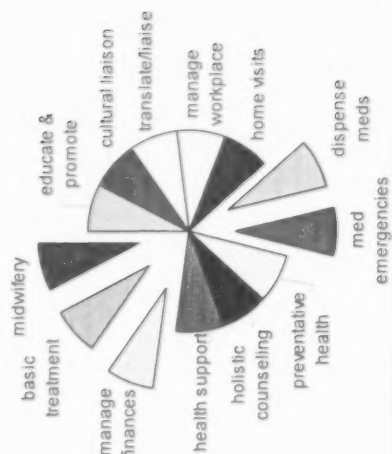
- if a domain was **selected** by any stakeholder: the domain will exist as a piece of the larger pie
- if a domain was **not selected** by all stakeholders: the domain will exist as a separate piece removed from the pie

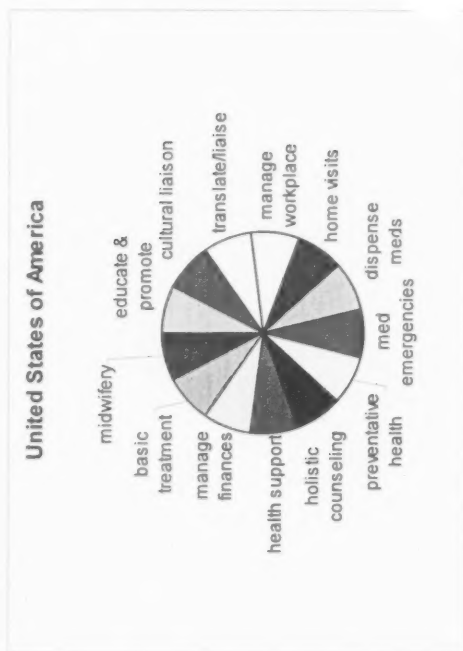


Australia



New Zealand





It was also identified by all countries that the work of the CHRAW differed depending on various factors including:

- rural/isolated area versus urban area
- differing state/provincial/territorial standards
- differing tribal/band expectations
- differing employment structures

Category 2: Organizational Structure

	CHRWs	National Government Office	Provincial/State/Territorial Government Office	CHRW Organization	Other
Canada	~ 1,000 CHRs	First Nations and Inuit Health Branch (FNIHB): provides funding	First Nations government – Band: establishes funding agreement with national government and employs CHRs	National Indian and Inuit Community Health Representatives Organization (NIICHO): advocacy/support	Advocacy/Support Groups: e.g., BC Health Care Associates
Australia	~ 1,400 Aboriginal and Torres Strait Islander Health Workers	The Commonwealth Office of Aboriginal and Torres Strait Islander Health (OATSIH): maintains funding structures	State/Territory Health Departments e.g. Northern Territory government's Department of Health and Community Services: employs health workers	National Association of Community-Controlled Health (NACCHO) & State/Territory groups e.g. the Professional Aboriginal Health Worker Association of South Australia (PAHWASA) : provide advocacy/support	Unions: e.g. Australian Workers Union (AWU), Health Services Union of Australia
New Zealand	Unknown number	New Zealand Ministry of Health: provides funding		Te Whiringa (charitable trust): receives funding from Ministry of Health and supports MCHWs	Employers
USA	~ 1,600 CHRs	Indian Health Service (IHS): promotes, honours and protects	12 IHS administrative units called Area Offices	National Association of Community Health Representatives (NACHR) Others providing support/advocacy	Advocacy/Support groups

Category 3: Budgets and Salaries

	Proposal of national budget	Source/allocation of funding	Determination of funding structure within community	Distribution to Health Workers	Consistency of salaries, budgets and benefits	Estimated salaries and benefits
Canada	Federal government through Treasury Board regulations; uses Community Workload Increase System (CWIS) funding formula to establish FNIHB funding.	Depends on employer (Health Canada, province, Band, Health Transfer agency). - The Band may sign a funding agreement. - Other programs may be used for funding (e.g. Brighter Futures)	Depends on the employer. - Long-term salaried positions. - Short-term contracts.	Transfer agreements allow for employer discretionary powers to determine rate of pay.	Large discrepancies across communities and across the country.	~ CAN \$16.25 per hour (Manitoba rate in 2000) because of discretionary powers, should be approximately CAN \$22.04 per hour if proper salary scale was used.
Australia	Office of Aboriginal and Torres Strait Islander Health (OATSIH)	OATSIH allocates a global budget for all Aboriginal and Torres Strait Islander health services.	Officially, there is an industry award which sets out the remuneration, conditions and benefits for government-employed Aboriginal Health Workers.	OATSIH provides funding to health services and individual employers distribute wages to workers.	There is no national consistency; there are differences between states and territories.	~AUD\$30,000 per year, range AUD\$20,000 - \$50,000 per year; benefits negotiated between employee/ employer
New Zealand	There is no national budget for Maori Community Health Workers (MCHW).	Employer establishes contract to employ MCHW.	Established by an individual employment contract.	Employer.	There is no national consistency.	There is no national estimate.
United States	Indian Health Services (IHS) and Department of Health and Human Resources	Varies according to the type/scope of services and the employing organization.	Varies according to the type/scope of services, regional location and the employing organization.	Employer.	There is no national consistency.	~ US\$15,000 - \$42,000 per year.

Category 4: Standards and Accreditation

Canada	• There is no national system of accreditation for CHR/Ws at this point... but much discussion and initiative. • "In July of 2003, a round-table discussion on standards and accreditation for CHR/Ws was coordinated by NIICHO (and attended by Health Canada, among other stakeholders) as a first step in the initiative to develop and manage national occupational standards of practice and accreditation for CHR/Ws in Aboriginal communities across Canada." • "In some provinces there is a ... community college diploma program that must be taken to work as a CHR but it is not always enforced at the local level in some communities." • "NIICHO offers National Training Sessions (to CHRs) once a year at the Annual General Assembly." "NIICHO also offers professional support through publication of its <i>In Touch</i> magazine and the development of various resources for its membership (e.g.: Diabetes, HIV/AIDS, Tobacco cessation, etc.)" • "CHR's roles have evolved in health promotion and prevention, client services, and demand of the CHRs a solid educational foundation complete with competencies that health care workers should possess to work in the communities." • "There should be a nationwide scope of practice with areas of specialties depending on education and location of employment ..." • "Upon graduation, the successful candidates should pass a national CHR examination. ... we should have to renew our accreditation and take updated professional development training on an ongoing basis to keep our competencies current." • "There should be prior learning assessments for CHRs who have work experience." • "There is a sentiment that higher education may mean that you cannot link as well to the grass roots/community level of interaction necessary for CHRs." • "A governing body needs to be adopted that can be impartial and maintain a professional stance..." • "The Metis Nation, Inuit, Medical Officers of Health, and the Federation of Indian Friendship Centres have requested that CHRs be placed in urban and Inuit communities that do not currently have CHRs. As it stands today, off-reserve or urban Aboriginal people do not have the access to CHRs." • "NIICHO would be an excellent organization to lead a national system of accreditation."
Australia	• There is no national system of accreditation for Health Workers at this point, but: "...the Aboriginal and Torres Strait Islander Health Worker National Competencies and Qualifications will be introduced in 2005. This will provide the basis for standards for Aboriginal and Torres Strait Islander Health Workers." It is proposed that OATSIH, Aboriginal and Torres Strait Islander Health Services, NACCHO and State/Territory Health Departments will be key organizations to initiating and overseeing the program. Similarly, employers will be charged with facilitating ongoing supervision, support and education. • "The introduction of Aboriginal and Torres Strait Islander Health Workers Competencies and Qualifications will standardize Health Worker training and recognized qualifications. It will also help to professionalize the sector as only those doing recognized training will be able to call themselves Aboriginal and/or Torres Strait Islander Health Workers." • "The new system will have some limitations and may reduce the capacity of people in remote areas with poor literacy from becoming Aboriginal or Torres Strait Islander Health Workers. However the proposal is to have a basic level of training with a qualification like Community Development that will enable these people to participate in Primary Health Care." • "Currently there is accredited training for Aboriginal Health Workers available, although only three jurisdictions access this training"

	framework – they provide training support mechanisms." "Generally certificates III and IV are accepted as the entry to point to become an Aboriginal or Torres Strait Islander Health Worker although this is not constant across the country. Consistency will come with the National Competencies and Qualifications."
New Zealand	"At present there is no national system of standards and accreditation for Maori Community Health Workers, but the Ministry of Health is in consultation with Te Whiringa and other interested stakeholders." "While there is no national system, various sectors have funded programs (e.g. Child and Family Health)." "The introduction of a Maori Community Health Worker national system of standards and accreditation will change the workforce and will strengthen the ability of workers to offer services to Maori people." "If a national system of accreditation is created, it must recognize the localized needs of each community including Maori cultural values; if not, then it will likely cause Maori families to further retract from accessing health services." "Clinicians and health professionals will value the higher education of the MCHW...." "Some training presently exists for MCHWs"
United States	"There is no national system of standards and accreditation for CHR/Ws, but some states/areas are attempting to establish standardization and credentialing bodies (e.g. Texas and Ohio)." "While there is no national system, 'the National Community Health Advisor Study has chronicled core roles and competencies for CHAs, but they are not mandated by any credentialing body nor are all of the roles and competencies required.'" "Some states have made significant moves... However, many of these steps have come under criticism because Community Health Workers have not been involved in the decision-making process for credentialing and/or certification. While a national system of accreditation has been discussed, the dialogue for and against such a system still needs further investigation." "...there is not a national body that governs Community Health Workers... (that would be responsible to initiate and oversee such a system of standards and accreditation). However, any agency that credentials or accredits Community Health Workers must be made up of Community Health Workers and have Community Health Workers in positions of power." "... a national system of accreditation would help standardize the profession and create career opportunities for the profession. Salaries, benefits and support mechanisms would also be strengthened, and standards/protocols would be in place. Another benefit is that Community Health Workers would have a stronger collective voice in advocating for their needs and profession." "However, many Community Health Workers may be excluded from the profession because they do not meet the requirements. Also, some Community Health Workers may feel restricted in their ability to do their job because protocols of care are rigid. Community Health Workers often pride themselves on their ability to adapt and meet the needs of their communities." - There is "concern about how to be inclusive of the different groups from different areas." - There is "concern that a national system of accreditation might create a barrier of distance with some at-risk communities. There are some Community Health Workers who can gain entry into communities based solely on who they are. If they were accredited, it might take away the relationship the Community Health Worker has with the community." - With regards to curriculum development and training/education, it is suspected that "many organizations will develop training/educational programs to meet the needs of the specific programs. Others will incorporate models that are currently in existence and adapt them to meet the needs of their programs. Still others will hire groups/consultants/programs (for training)." "Ongoing supervision, support and education are important topics to many Community Health Workers."

Category 5: Professional Relationships

Canada	• "In general, CHR's have said that they feel their opinion is not respected... With accreditation, CHR's will be better recognized... Also having scope of practice determined, health workers will know each other's boundaries and ensure a better work environment." • "In my community, based on my level of education and work experience, other health care professionals treat me with a high degree of respect. I have a high skill set and willingness to learn more advanced skills to benefit the clients in my semi-remote community. Others see my role in the community as a great assist and a complement to the services that they provide their patients." • "If there is no system/standard, then the relationships would remain unchanged and the clients would be at a disadvantage. For instance, previously it was nothing for a CHR to dispense OTC medications, change dressings, read TB results, or take a glucometer reading; now many nurses and physicians are second-guessing the roles of CHR's because of regulations and legislations, especially liability issues." • "My experience is that the majority of health care professionals have never heard of the CHR role, or if they have, their understanding of it is relatively poor." "On the other hand, I also know that those of us who have worked extensively with CHR's have a great deal of respect for the importance of the CHR role." • "The health scenario would be enhanced with accreditation/standards because expectations, roles, and responsibilities would be delineated and standardized across the country. We would be making the most effective use of each and every member of the community health team." • "With systems of accreditation/standards in place, the relationship may improve or the process may ostracize the CHR and CHW from the non-First Nations professionals."
Australia	• "In remote clinics and other settings, Aboriginal Health Workers are supervised by Registered Nurses but they carry out activities which are more senior and complex than enrolled nurses do." • "Unless the qualifications of Aboriginal Health Worker are brought into the same training framework of other health worker, they will exist in isolation and these workers will continue to be marginalized as they are currently." • "The Aboriginal and Torres Strait Islander Health Worker accreditation system will professionalize the sector and provide improved standing for Aboriginal and Torres Strait Health Workers."
New Zealand	• "Typically MCHWs are seen to be 'at the bottom of the heap'. MCHWs are not required to have set qualifications and therefore they are not considered professional by other medical professionals." • "(They are) supported to an extent in terms of value of role but often not viewed as part of the health team. Often the MCHW is referred to where there are social issues and the holistic approach to health services is not always embraced." • "The MCHW is often seen as the advocate for the extended family and the interpreter and conduit between the health sector and the family." • "It would be good for other health professionals to understand and appreciate the defined role and of the MCHW; this might come with a system of standards and accreditation."

United States	• "Limited recognition by other professionals -- particularly outside of Indian Health Services." • "The relationship with other health and social services professions certainly depends on the location and type of program. Overall, Community Health Workers are essential to any program. However, many Community Health Workers are not respected as essential, integral members of the health care team. They are often called paraprofessionals, alluding to the idea that they are not real health professionals. They are the first to be cut when budget cuts are made, and they are often criticized for not conforming to the medical paradigm. Because community health does not happen between the hours of 9 am - 5 pm, many health professionals do not understand who Community Health Workers are, what they do, and how important they are to the success of a program." • "Community Health Workers' skills are often devalued... Some programs feel that only the health professional can make presentations or represent the organization to stakeholders, but they expect Community Health Workers to deliver on all other aspects. Community Health Workers are often not invited to deliver presentations at state and national conferences, even though they are the ones most knowledgeable about the program." • "On the other hand, many Community Health Workers work well with health professionals. Most Community Health Workers have the community's wellness at heart, and they will try to accomplish what is in the best interest of the community." • "... a system of accreditation might be beneficial to Community Health Workers because it will define who CHR/Ws are and what they do. This will allow for the Community Health Worker profession to become standardized, and their scope of knowledge and skills would become valued." • "On the other hand, many Community Health Workers do the jobs of some health educators, nurses, and social workers, and this might threaten some of those professions. It could create additional strife."
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Category 6: Challenges and Best Practices

Canada	Key challenges: • "Lack of: - o ongoing standardized training and upgrading of skills - o recognition by the formal health care system and hence underutilization of this group of workers; e.g. legitimacy of the CHR role ... is not perceived as being a "viable" or legitimate health career by other health care professionals - o portability/mobility across geographic areas due to lack of national standards and accreditation - o supervision; unhealthy workplace environments - o networking opportunities and opportunities for career advancement - o standardized and fair salaries" • "Confusion that gets created by the myriad of front-line cultural health workers, who have a variety of names, job descriptions, and training (yet who also share the same basic set of core competencies)." • "CHRs who have received ad hoc, on-the-job training receive no credit for their knowledge and skills when they decide to further their education." • "The need to organize provincial associations to lobby for recognition as unique health care providers, with mandatory registration and exclusive right to title." • "Access to education is limited for those who wish to attend a college certificate program; there is a need for more flexible delivery, possibly combining distance delivery (either print-based or online) with face-to-face delivery close to the student's home." • "Excess demands to meet community needs (too many duties, not enough time)." • "Some CHRs may lack the capacity to achieve accreditation. As front-line workers, their main function is in dealing with the people in their community. They have great people skills but may have poor writing or math skills, this would affect them in getting accredited. Thus we could have fewer CHRs when actually there is a need to increase the number of CHRs." • "NIICHO, in collaboration with stakeholders, could develop and implement a system of accreditation, but the adoption of such a program still comes down to the Band. Bands could decide not to participate in the initiative. Even with the support of the political will of the Assembly of First Nations, a Chief and Council could potentially opt out as is their right." Best practices: • "There is widespread recognition that CHR/Ws play an important role in health care, health education, and health promotion in First Nations and Inuit communities. The CHR is frequently the essential provider of health services, particularly in northern, remote, and/or isolated communities where there are no other health professionals or where retaining nurses has proven difficult." • "Both national and regional Aboriginal associations have supported the expansion and enrichment of the CHR program over the years, including supporting the concept of developing national occupational standards and accredited training for CHRs." • "Keeping in mind the need for best practices in all areas of the health care system, it is imperative for the CHR profession to have a scope of practice and professional standards that will be implemented and evaluated and that includes ongoing certification and
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	methods of discipline for professional misconduct. This would ensure the clients are receiving a high quality of services across the nation and also provide security and guidance for the people working in the profession." "After over 40 years of existence, the CHR program is still considered an important element of the health field and is the best way to reach the grass roots of health in any community. One element of a CHR's job is the home visit and some have said that this is considered one of the strongest aspects of their job as they know the problems of their community and can advocate for the needs of these community members who otherwise are unable to bring their needs to the forefront." "In many northern and isolated communities, the turnover of health professionals, and particularly Registered Nurses, is extremely high. The CHR provides the ONLY continuity of care that people in these communities have."
Australia	Key challenges: "The key challenges are working in an environment which has some of the worst indigenous health outcomes in other than the Third World. Indigenous health outcomes in remote settings have been described as worse than some Third World countries. Training as Aboriginal Health Workers is complex and exacerbated by low literacy and numeracy levels and inadequate housing and essential services infrastructure." "There is a difficulty around the way in which the role of Aboriginal Health Workers has evolved. Initially the workers were supposed to be cultural brokers and cultural interpreters. Now that role seems to have diminished and they are being trained to be Aboriginal equivalents of nurses, without the full scope of learning, any acknowledgement of the role or place in the hierarchical structure. There is certainly no robust data that supports their role having made an impact on primary health levels in remote settings." "Key challenges include professionalizing the sector and establishing associations."
New Zealand	Key challenges: "Lack of: ○ pay parity ○ coordinated approach for MCHWs in terms of career pathways, recruitment, attrition and retention ○ understanding by other health professionals of MCHW grass-roots work ○ knowledge around cultural needs and norms that need to be at the forefront of competency development ○ respect for MCHW and their role by the health professionals" Best practices "MCHWs are culturally sound/connected to the Māori people." "MCHWs communicate well with the Māori people." "MCHWs advocate for the Māori people."

United States	Key challenges • "Most Community Health Workers are overworked and underpaid. Many Community Health Workers live in the very populations that are labeled as underserved and low-income." • "Education, career ladders, and credentialing are key challenges. While many Community Health Workers receive certificates from training that they have completed, these certificates often have no monetary compensation for completion and cannot be transferred from program to program." • "The roles and competencies of Community Health Workers are misunderstood and undervalued. Community Health Workers are not valued as health professionals. They are seen as paraprofessionals. Many people do not understand who Community Health Workers are and what they do." • "Some Community Health Workers are paid, and some are volunteers. A clear delineation of the role between both paid and volunteer Community Health Workers is needed to strengthen program practice." • "Community Health Workers have not come together as one entity to advocate for their profession." Best practices • "College programs in San Fran and Arizona" • "At the Center for Sustainable Health Outreach, there are several model programs that are considered best practices: ○ The Community Health Advisor Network (CHAN) program promotes individual self-reliance by empowering volunteer natural helpers to solve health and wellness problems. This program is a volunteer-based Community Health Worker program and is unique because it is non-prescriptive in nature. The community decide their health priority issues, and they determine their steps to action and solutions to the issues. ○ The Maternal Infant Health Outreach Worker (MIHOW) program is a community-based home visiting program aimed at improving family health and early childhood development for low-income families. ○ Deep South Network for Cancer Control (DSNCC) is an adaptation of the Community Health Advisor Network Program. While CHAN is non-prescriptive health promotion, DSNCC is focused on a specific disease, cancer."
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Report Summary

In October 2003, the International Network in Indigenous Health Knowledge and Development (INIHKD) meeting in Townsville, Australia proved to be the impetus for international discussion (from Australia, Canada, New Zealand and the United States of America) regarding Community Health Representatives/Workers. Indeed, during that meeting, it was acknowledged that each of these four countries maintained Community Health Representatives/Workers (CHR/Ws) as an integral part of their indigenous health care system and each of the four countries seemed to be facing similar issues and challenges – particularly with respect to 'scope of practice'. As this report supports, CHR/Ws from the four countries do indeed share particular concerns and challenges, albeit within their unique national cultures.

This report presents valuable information that the four countries can use to learn from one another and perhaps use to assist in future initiatives. In particular, each country can explore the perspectives of their international colleagues regarding the following:

- historical overview of the indigenous peoples in each country
- review of the evolution of CHR/Ws and the developments regarding scope of practice for CHR/Ws in each country (including specific initiatives and projects)
- analysis of survey questionnaire data that addressed
 - o job description/scope of practice
 - o organizational structure
 - o budgets and salaries
 - o standards and accreditation
 - o professional relationships
 - o challenges and best practices

Amidst the information, and with respect of the differences among nations, some themes resound throughout this report and include that:

- the work towards defined scope of practice and standards/accreditation for CHR/Ws is critical
- any work to this end should involve indigenous people and indigenous CHR/Ws
- all work should be culturally sensitive
- all work should be sensitive to regional, geographical, political and cultural limitations or parameters
- processes of standards/accreditation should allow for flexibility without weakness
- processes should be sensitive to the role of the CHR/W as a grass-roots connection to the community members
- processes should be sensitive to and supportive of professional relationships.

Indeed, this study provides an opportunity to learn and share with other governments, communities, advocates and stakeholders regarding CHR/Ws in indigenous communities. As we enter into an era where the work of CHR/Ws is becoming more recognized for its unique and critical importance to indigenous communities, it is a time when our nations can turn to one another to explore common challenges and issues. In particular at this time, our nations turn to one another in support of our mutual interests in the evolution and advancement regarding the scope of practice, standards, certification and accreditation for the CHR/Ws in our respective indigenous communities.

The data within this study should prove valuable to all involved with the structuring of policies and strategies and with the development, review and revision of standards of practice and systems of accreditation for CHR/Ws. As well, the information (including acknowledgement of key international CHR/W stakeholders) should prove valuable to the organizers of the next International Network in Indigenous Health Knowledge and Development (INIHKD) Forum, which is being planned for October 2005 in the host nation of Canada.

Appendix A: Key Stakeholders and Contacts

CANADA

Organization/Contact	Contact Information
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* First Nations and Inuit Health Branch (FNIHB)	* Pat Allen: Health Promotion and Education Advisor, Health Canada – First Nations and Inuit Health Branch Pat.Allen@hc-sc.gc.ca
Colleges/Universities	Debra Ransom – Instructor, Portage College debra.ransom@portagec.ab.ca
Provincial representatives	Wayne Christian, Executive Director, Community Health Associates of BC wmchristian@shawcable.com www.cha-bc.org

AUSTRALIA

Organization	Contact
Office for Aboriginal and Torres Strait Islander Health (OATSIH)	Michael Fisher Michael.Fisher@health.gov.au Aaron Briscoe Aaron.Briscoe@health.gov.au Tony Kiessler Tony.Kiessler@health.gov.au
* National Aboriginal Community-Controlled Health Organization (NACCHO)	* Bridget Carrick, Workforce Policy Officer Bridget@naccho.org.au
Professional Aboriginal Health Workers Association of South Australia (PAHWASA)	Eddie Moore, CEO eddie.moore@pahwasa.com.au

* Community Services and Health Industry Skills Council (CS&H Industry Skills Council))	* Di Lawson , Chief Executive Officer di.lawson@cshisc.com.au Natalie Collison, Project Co-ordinator natalie.collison@cshisc.com.au
Human Services Training Advisory Council Inc. (HSTAC)	Ms. Barbara Pitman, Executive Director b.pitman@hstac.com.au

NEW ZEALAND

Organization	Contact Information
* Te Whiringa Trust National Māori Community Health Workers Group / National Association	* Manu Graham Chair, Te Whiringa Trust manu.g@xtra.co.nz
Tipu Ora Charitable Trust (Māori Health Provider in Rotorua) & Te Whiringa Trust	Kirsten Rei Training Manager – Tipu Ora Charitable Trust Trustee and Executive Member – Te Whiringa KRei@tipuora.org.nz
* Hauora.com National Māori Health Workforce Development Organization	* Kris MacDonald, General Manager, Māori Health KrisM@adhb.govt.nz Brigham Anderson brighama@hauora.com
National Council of Māori Nurses	Sharon Lambert sharonlambert@xtra.co.nz

UNITED STATES

Organization	Contact Information
* Indian Health Services	* Cathy Stueckemann, Public Health Advisor CHR and EMS Programs Cstuecke@na.ihs.gov
Center for Sustainable Health Outreach (CSHO)	Susan Mayfield-Johnson, Program Coordinator Susan.Johnson@usm.edu Dr. Agnes Hinton, Director agnes.hinton@usm.edu
* National Association of Community Health Representatives (NACHR)	* Cynthia Norris President, NACHR NorrisC@TODHS.com
Consultant and Advocate	E. Lee Rosenthal Ph.D., M.P.H. Consultant to Opening Doors/FIPSE (Fund for Improved Post-secondary Education) Project Mesa Public Health Associates lee.mesa@cox.net
* Community Health Aide Program of Alaska	* Torie Heart RN, MS – Director Community Health Aide Program vheart@anmc.org

* indicates those individuals/organizations who initially offered support as stakeholders within the project, but who were not able to complete the survey questionnaire for various reasons.

Appendix B: Valuable Resources

Canada:

Standards and Accreditation for Community Health Representatives: Summary Report of Round-table Discussion Meeting (July 2003) (McCulla, 2003)

National Indian and Inuit Community Health Representatives Organization (NIICHRO)
P.O. Box 1019, One Roy Montour Lane, Kahnawake, Quebec, Canada, J0L 1B0
Ph: (450) 632-0892 Fax: (450) 632-2111
niichro@niichro.com

The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper (Ship, 1998; revised by Butler, 2003)

National Indian and Inuit Community Health Representatives Organization (NIICHRO)
P.O. Box 1019, One Roy Montour Lane, Kahnawake, Quebec, Canada, J0L 1B0
Ph: (450) 632-0892 Fax: (450) 632-2111
niichro@niichro.com

Community Health Worker Job Classification Model (June 1999)

Community Health Associates of British Columbia
#2 - 3003 29th Avenue, Vernon, B.C., Canada, V1T 1Y9
Ph: (250) 503-1123 Fax: (250) 503-1733
www.cha-bc.org/

Legal Issues & the Role of the CHR (Community Health Representative)

Kay Half, CHR, Regional CHR Coordinator, FNIHB (Alberta Region)
Debra Ransom, RN, Portage College Instructor – CHR Program
Copyright: Portage College and FNIHB (Alberta), 2003
www.portagecollege.ca

Scope of Practice for Community Health Representatives (CHRs) (Alberta) (June 2003)

First Nations and Inuit Health Branch (FNIHB) – Alberta Region of Health Canada and
Portage College (Community Health Representative Program)
www.portagecollege.ca
www.hc-sc.gc.ca/fnihb-dgspni/fnihb/

Various university/college/training programs:

Portage College (Alberta), Mohawk College (Ontario), Yellowquill College (Manitoba), Okanagan University College (British Columbia), etc.

Australia:

National Review of Aboriginal and Torres Strait Islander Health Worker Training

A report submitted to the Office for Aboriginal and Torres Strait Islander Health.
Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation
Consortium and Jojara & Associates (1999)
Available from the Office for Aboriginal and Torres Strait Islander Health (OATSIH)
www.health.gov.au/oatsih/pubs/healthworker.htm

Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards and Qualifications Project

Community Services and Health Industry Skills Council
(previously Community Services and Health Training Australia)
Project Co-ordinator: Natalie Collison

Ph: (02) 9263 3589
admin@cshisc.com.au
http://www.cshisc.com.au/view_page.asp?ID=15

Standing Committee on Aboriginal and Torres Strait Islander Health: *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*

Australian Health Minister's Advisory Council (AHMAC) - Canberra (May 2002)
Available from the Office for Aboriginal and Torres Strait Islander Health (OATSIH)
Department of Health and Ageing
GPO Box 9848, Canberra, ACT, Australia, 2601
Ph: (02) 6289 5279 Fax: (02) 6289 1412
oatsih.enquiries@health.gov.au
www.health.gov.au/oatsih/index.htm
Publications approval number 3049

New Zealand:

hauora.com
maori health community
www.hauora.com

United States of America:

The Final Report of the National Community Health Advisory Study and A Summary of the National Community Health Advisor Study

(E. Lee Rosenthal – Study Director, 1998; reprinted, 2000)
A Policy Research Project of the University of Arizona Funded by the Annie E. Casey Foundation
Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD, United States, 21202
Ph: (410) 223-2890 Fax: (410) 547-6624
<http://www.aecf.org/>
cha@ahsc.arizona.edu

The Community Access to Care Community Health Worker Inventory Project

Center for Sustainable Health Outreach (CSHO) in partnership with the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy; Funded by the W.K. Kellogg Foundation.
Contact: Paul Philpot
Ph: (601) 266-6709
Paul.Philpot@usm.edu

A National Community of Practice Initiative for Community Health Worker Post-secondary Programs

FIPSE Community of Practice Initiative National Advisory Committee
Contact: E. Lee Rosenthal, lee.mesa@cox.net

Appendix C: Survey Questionnaire Questions

CATEGORY 1 QUESTIONS: Job Description/Scope of Practice

1. What is the definition/description of a CHR/W in your nation?

2. Consider the following domains of work to define/describe the 'scope of practice' of a CHR/W in your nation. Please check the appropriate boxes that apply to CHR/W work in your nation and use the space below to list any 'other' domains of work or provide further details.

- | | |
|---|---|
| ☐ focus on health education and promotion | ☐ organize preventative health care |
| ☐ act as cultural liaison/advocate for health | ☐ provide health-related counseling |
| ☐ communicate/liaise/translate between health clients and health professionals | ☐ provide health-related support to clients with diagnosed needs |
| ☐ support managerial/workplace demands | ☐ support management of finances/resources |
| ☐ home visitations to clients | ☐ provide basic medical treatment |
| ☐ dispense medications | ☐ midwifery |
| ☐ respond to medical emergencies | |

3. Do the domains of work for a CHR/W differ depending on different factors? Below are some examples of different factors. Please explain your answer in the space provided.

- | | |
|--|---|
| ☐ rural/isolated area versus urban area | ☐ differing state/provincial/territorial standards |
| ☐ differing tribal/band expectations | ☐ other _____ |

4. Consider the following questions and provide your answer as fact or opinion:

- a) What was the original intent of the CHR/W program in your nation?
b) Has the CHR/W program in your nation been successful?

CATEGORY 2: Organizational Structure

5. Indicate the governing body for CHR/Ws in your nation by checking the appropriate box below and by describing their role. If there is more than one governing body, please describe the relationships of those governing bodies to the CHR/Ws and to each other; (note: if it is easier to use a sketch/flow-chart, please feel free to do so).

- ☐ national government office: _____
role: _____
- ☐ provincial/state/territorial government office: _____
role: _____
- ☐ CHR/W organization: _____
role: _____
- ☐ other association(s): _____

6. What methods does the governing body (or bodies) use to communicate with and monitor CHR/Ws?

7. Are CHR/Ws in your nation required to be members of a professional or representative CHR/W organization? If 'yes', then to what organization and what are the requirements of membership?

Required membership (YES/NO): _____

Organization: _____

Requirements of Membership: _____

8. If membership to a professional or representative organization is required, then how are regulations/guidelines of membership enforced?

9. Who professionally disciplines a CHR/W when a (health) regulation is broken?

10. What are the statistical numbers of CHR/Ws in your nation -

a) in total? _____

b) who are working members of representative CHR/W organizations meeting specific regulation requirements? _____

c) who are working but not holding membership in an official CHR/W organization and not meeting specific regulation requirements? _____

11. What are the recruitment strategies for CHR/Ws?

CATEGORY 3: Budgets and Salaries

12. Who proposes the national budget for CHR/Ws?

13. Who sources/allocates the funding for CHR/Ws (e.g.: salaries, resources and support)?

14. How are the salaries, resource funds and benefits for CHR/Ws in communities determined?

15. How are CHR/W salaries and resource funds distributed?

16. Are salaries, resource budgets and benefits for CHR/Ws consistent nationwide? Please explain.

17. What is the average salary for a CHR/W? If there is a salary scale, please indicate such. If there is significant variance nationwide, please indicate why.

18. Describe the average benefit package and support structure provided for CHR/Ws. If there is significant variance nationwide, please indicate why.

CATEGORY 4: Standards and Accreditation

19. Is there a national system of accreditation for CHR/Ws wherein certain standards and requirements of work are officially recognized and officially required by a representative association or governing body?

20. a) If there is a national system of accreditation, when was this system of accreditation first introduced?

b) If there is not a national system of accreditation, is there any degree of established standards (e.g.: certification and/or skill requirements) for CHR/W work? For example, are there state or provincial standards? Is such a national system of accreditation being considered?

21. a) If there is a national system of accreditation for CHR/Ws, what agencies are responsible for overseeing the accreditation process and requirements?

b) If there is not a national system of accreditation, what agency might be responsible for initiating and overseeing such a system?

22. If there is a national system of accreditation for CHR/Ws, please describe the standards that are required to be met?

23. If there is a system of accreditation for CHR/Ws, what provisions are made for CHR/Ws from an older age group? For example, is *prior learning assessment* or *credentialing* utilized wherein an individual's experience might be recognized in lieu of certification. If *prior learning assessment* or *credentialing* is utilized, please explain how it is utilized.

24. a) If there is a national system of accreditation for CHR/Ws, has it changed the workforce and how the work of CHR/Ws is being done?

b) If there is not a national system of accreditation for CHR/Ws, what is your opinion about how such a system might change the workforce and how the work of CHR/Ws is being done? For example, is such a system an opportunity to make the work of CHR/Ws more or less meaningful?

25. a) If there is a national system of accreditation for CHR/Ws, have the more strict requirements (e.g.: higher education levels) taken CHR/Ws away from the community grass-roots level and/or style?

b) If there is not a national system of accreditation, what is your opinion on how such a system – with its more strict requirements (e.g.: higher education levels) – might affect the community grass-roots level and/or style traditionally held by CHR/Ws?

26. a) If there is a national system of accreditation, what types of training/education programs are in place for CHR/Ws to address accreditation requirements?

b) If there is not a national system of accreditation, what types of training/education programs are in place (or are being developed) for CHR/Ws to address needs/requirements?

27. a) If there is a national system of accreditation, what mechanisms are in place for CHR/Ws to provide ongoing supervision, support and education?

b) If there is not a national system of accreditation, what mechanisms are in place for CHR/Ws to provide ongoing supervision, support and education?

CATEGORY 5: Relationships

28. Describe the relationships of CHR/Ws with other health professionals in your nation.

29. a) If there is a system of accreditation for CHR/Ws, how are relationships of CHR/Ws with other health professionals impacted by the existence of that system?

b) If there is not a system of accreditation for CHR/Ws, what is your opinion on how relationships of CHR/Ws with other health professionals might be impacted by the existence of such a system?

CATEGORY 6: Key Challenges and Best Practices

30. Describe "key challenges" facing CHR/Ws in your nation.

31. Describe some "best practices" with respect to CHR/Ws in your nation.

32. Please feel free to provide any additional comments.

References

- ¹ Wikipedia. *Indigenous People*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Indigenous_people
- ² Constitution Act of Canada: Section 35(2). 1982.
- ³ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-98: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ⁴ Smylie, Janet & the Aboriginal Health Issues Committee: Society of Obstetricians and Gynaecologists of Canada. (2001). *SOGC Policy Statement: A Guide for Health Care Professionals Working with Aboriginal Peoples*. Journal SOGC: April, 2001. Rogers Media: Toronto, Ontario. Reprinted from the Journal SOGC. 2000-2001: vol. 22/12, vol. 23/1, vol. 23/2, vol. 23/3.
- ⁵ Isaac, T. *An Introduction to Aboriginal Issues*. Journal SOGC. 1995: 17/583-5.
- ⁶ Smylie, Janet & the Aboriginal Health Issues Committee: Society of Obstetricians and Gynaecologists of Canada. (2001). *SOGC Policy Statement: A Guide for Health Care Professionals Working with Aboriginal Peoples*. Journal SOGC: April, 2001. Rogers Media: Toronto, Ontario. Reprinted from the Journal SOGC. 2000-2001: vol. 22/12, vol. 23/1, vol. 23/2, vol. 23/3.
- ⁷ IBID
- ⁸ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-98: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ⁹ http://www.hc-sc.gc.ca/fnihb/sppa/hia/publications/statistical_profile.htm
- ¹⁰ Wikipedia. *Australian Aborigine*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Australian_Aborigines
- ¹¹ Wikipedia. *Australian Aborigine*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Torres_Strait_Islanders
- ¹² Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ¹³ Wikipedia. *Australian Aborigine*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Australian_Aborigines
- ¹⁴ Wikipedia. *Australian Aborigine*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Australian_Aborigines
- ¹⁵ IBID.
- ¹⁶ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ¹⁷ Curtin Indigenous Research Centre. *A National Review of Aboriginal and Torres Strait Islander Health Worker Training: A Report Submitted to the Office for Aboriginal and Torres Strait Islander Health*. Retrieved February 2004 from: <http://www.health.gov.au/oatsih/pubs/healthworker.htm>
- ¹⁸ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>

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- ¹⁹ Wikipedia. *Māori*. Retrieved February 2004 from: <http://en.wikipedia.org/wiki/Māori>
- ²⁰ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ²¹ Wikipedia. *Māori*. Retrieved February 2004 from: <http://en.wikipedia.org/wiki/Māori>
- ²² IBID.
- ²³ New Zealand in History. *The Māori*. Retrieved February 2004 from: <http://history-nz.org/Māori7.html>
- ²⁴ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ²⁵ New Zealand in History. *The Māori*. Retrieved February 2004 from: <http://history-nz.org/Māori7.html>
- ²⁶ Smylie, Janet & the Aboriginal Health Issues Committee: Society of Obstetricians and Gynaecologists of Canada. (2001). *SOGC Policy Statement: A Guide for Health Care Professionals Working with Aboriginal Peoples*. Journal SOGC: April, 2001. Rogers Media: Toronto, Ontario. Reprinted from the Journal SOGC. 2000-2001: vol. 22/12, vol. 23/1, vol. 23/2, vol. 23/3.
- ²⁷ Wikipedia. *Native America*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Native_Americans
- ²⁸ IBID.
- ²⁹ Indian Health Service. (2002). *Indian Health Service: Fact Sheet*. Retrieved February 2004 from: http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp
- ³⁰ IBID
- ³¹ Treaty Rights – Understanding the Context. Historical Context: History of "Indian Policy." Retrieved February 2004 from: <http://www.fw.umn.edu/Indigenous/history/htm>
- ³² Wikipedia. *Native America*. Retrieved February 2004 from: http://en.wikipedia.org/wiki/Native_Americans
- ³³ Treaty Rights – Understanding the Context. Historical Context: History of "Indian Policy." Retrieved February 2004 from: <http://www.fw.umn.edu/Indigenous/history/htm>
- ³⁴ Parliament of Australia: Parliamentary Library. *Background Paper 15 1997-1998: Indigenous Affairs in Australia, New Zealand, Canada, United States of America, Norway and Sweden*. Retrieved February 2004 from: <http://www.aph.gov.au/library/pubs/bp/1997-98/98bp15.htm>
- ³⁵ Smylie, Janet & the Aboriginal Health Issues Committee: Society of Obstetricians and Gynaecologists of Canada. (2001). *SOGC Policy Statement: A Guide for Health Care Professionals Working with Aboriginal Peoples*. Journal SOGC: April, 2001. Rogers Media: Toronto, Ontario. Reprinted from the Journal SOGC. 2000-2001: vol. 22/12, vol. 23/1, vol. 23/2, vol. 23/3.
- ³⁶ Canadian Public Health Association (CHPA). 1997. *Exploring Occupational Standards for Aboriginal Health Workers: Executive Summary*. Ottawa.
- ³⁷ Indian Health Policy 1979. Retrieved May 2004 from: http://www.hc-sc.gc.ca/fnihb/bpm/hfa/transfer_publications/indian_health_policy.htm
- ³⁸ Strategic Policy, Planning and Analysis. Retrieved May 2004 from: <http://www.hc-sc.gc.ca/fnihb/sppa/index.htm>

³⁹ Health System: Canadian Health Network. Retrieved May 2004 from <http://www.canadian-healthnetwork.ca>

⁴⁰ Ship, S.J. (1998). *The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper*. Revised June 2003 by Shelley Butler. National Indian and Inuit Community Health Representatives Organization (NIICHO).

⁴¹ National Indian and Inuit Community Health Representatives Organization (NIICHO). 1991. *Community Health Representative Program Issues and Concerns: Discussion Paper*. Ottawa: Unpublished.

⁴² Royal Commission on Aboriginal Peoples. (1996). *Gathering Strength: Volume 3*. Ottawa: Canada Communications Group.

⁴³ Assembly of First Nations (AFN). (1988). *Summary of Recommendations: Proposals to Enrich and Expand the Community Health Representative Program*. Ottawa.

⁴⁴ Ship, S.J. (1998). *The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper*. Revised June 2003 by Shelley Butler. National Indian and Inuit Community Health Representatives Organization (NIICHO).

⁴⁵ National Indian and Inuit Community Health Representatives Organization. Retrieved February 2004 from: <http://www.niichro.com/Contents.html>

⁴⁶ NIICHO (2003). *The Development of National Occupational Standards for Community Health Representatives: Executive Summary*. Based on the Issues Identification Paper (Ship, 1998; revised by Butler, 2003). National Indian and Inuit Community Health Representatives Organization (NIICHO).

⁴⁷ Ship, S.J. (1998). *The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper*. Revised June 2003 by Shelley Butler. National Indian and Inuit Community Health Representatives Organization (NIICHO).

⁴⁸ McCulla, K. (2003). *Round-table Discussion on Standards and Accreditation for Community Health Representatives*. National Indian and Inuit Community Health Representatives Organization (NIICHO).

⁴⁹ Curtin Indigenous Research Centre. *A National Review of Aboriginal and Torres Strait Islander Health Worker Training: A Report Submitted to the Office for Aboriginal and Torres Strait Islander Health*. Retrieved February 2004 from: <http://www.health.gov.au/oatsih/pubs/healthworker.htm>

⁵⁰ IBID.

⁵¹ Office of Aboriginal and Torres Strait Islander Health. *Aboriginal and Torres Strait Islander Health Worker Training Review*. Retrieved June 2004 from: <http://www.health.gov.au/oatsih/pubs/healthworker.htm>

⁵² Curtin Indigenous Research Centre. *A National Review of Aboriginal and Torres Strait Islander Health Worker Training: A Report Submitted to the Office for Aboriginal and Torres Strait Islander Health*. Retrieved February 2004 from: <http://www.health.gov.au/oatsih/pubs/healthworker.htm>

⁵³ Community Services and Health Industry Skills Council (previously Community Health Services and Health Training Australia). *Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards and Qualifications Project*. Retrieved February 2004 from: http://www.cshisc.com.au/view_page.asp?ID=15

⁵⁴ IBID.

⁵⁵ Aboriginal Health Worker and Torres Strait Islander Health Worker: Project Background. Retrieved June 2004 from: http://www.cshisc.com.au/view_page.asp?ID=15#background

⁵⁶ IBID.

-
- ⁵⁷ Community Services and Health Training Australia Limited. Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project. Retrieved June 2004 from: http://www.cshsta.com.au/view_page.asp?ID=15
- ⁵⁸ Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project: Project Background. Retrieved June 2004 from: http://www.cshsta.com.au/docs/upload/A&TSI_background.pdf
- ⁵⁹ Community Services and Health Training Australia Limited. Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project. Retrieved June 2004 from: http://www.cshsta.com.au/view_page.asp?ID=15
- ⁶⁰ New Zealand in History. *The Māori*. Retrieved February 2004 from: <http://history-nz.org/Māori7.html>
- ⁶¹ Māori Health: About Māori Health. Retrieved June 2004 from: http://www.Māorihealth.govt.nz/about_mh/
- ⁶² Māori Health: Addressing Māori Health. Retrieved June 2004 from: <http://www.Māorihealth.govt.nz/addressing/>
- ⁶³ IBID.
- ⁶⁴ Hauora.com: Executive Summary. Retrieved June 2004 from: <http://www.hauora.com/about/index.cfm?fusesubaction=doc&DocumentID=2>
- ⁶⁵ Indian Health Service. *Indian Health Manual*. Maryland Office of Public Health, CHR Program, 1991.
- ⁶⁶ Activity/Mechanism Budget Summary: Department of Health and Human Services – IHS. CHR Program. Retrieved May 2004 from: <http://www.ihs.gov/adminmngresources/budget/downloads/fy%5F2005/community%20health%20representatives.doc>
- ⁶⁷ Legal Information Institute: U.S. Code Collection. Title 25, Chapter 18, General Provisions, Section 1616. Retrieved June 2004 from: <http://www4.law.cornell.edu/uscode/25/1616.html>
- ⁶⁸ Ship, S.J. (1998). *The Development of National Occupational Standards for Community Health Representatives: Issues Identification Paper*. Revised June 2003 by Shelley Butler. National Indian and Inuit Community Health Representatives Organization (NIICHO).
- ⁶⁹ FIPSE Community of Practice Initiative. 2004. A National Community of Practice Initiative for CHW Post-secondary Programs. Retrieved from E. Lee Rosenthal @ lee.mesa@cox.net
- ⁷⁰ Community of Sustained Health Outreach (CSHO). 2004. The Community Access to Care Community Health Worker Inventory Project. Retrieved from Paul Philpot: Paul.Philpot@usm.edu
- ⁷¹ Department of Health and Human Services: Office of the Inspector General. 1993. Revitalizing the Community Health Representative Program. OEI-05-91-01070.
- ⁷² A Summary of the National Community Health Advisor Study. (1998; reprinted 2000). A Policy Research Project of the University of Arizona, Funded by the Annie E. Casey Foundation. E. Lee Rosenthal – Study Director.

